211 CMR 71.00: MEDICARE SUPPLEMENT INSURANCE AND EVIDENCES OF COVERAGE ISSUED PURSUANT TO A RISK OR COST CONTRACT -- TO FACILITATE THE IMPLEMENTATION OF M.G.L. c. 176K AND SECTION 1882 OF THE FEDERAL SOCIAL SECURITY ACT

Section

71.01: Purpose

The purpose of 211 CMR 71.00 is to provide for the implementation of M.G.L. c. 176K and Section 1882 of the federal Social Security Act; to provide for the reasonable standardization and simplification of the terms, benefits, organization and format of Medicare Supplement Insurance policies; to facilitate public understanding and comparison of such policies; to ensure that policies are written in an easily understood manner; to provide for the full disclosure of Policy contents; to eliminate provisions contained in such policies which may be misleading or confusing in connection with the purchase of such policies or with the settlement of claims; to prevent the sale of coverage which does not in fact complement Medicare; to ensure fair marketing; to prevent deceptive sales practices; to provide for full disclosure in the sale of accident and sickness insurance coverage to persons eligible for Medicare; to provide standards for Evidences of Coverage Issued Pursuant to a Risk or Cost Contract; and to facilitate review of rates for Medicare Supplement Insurance and Evidences of Coverage Issued Pursuant to a Cost Contract.

71.02: Applicability, Scope and Effective Date

(1) Except as otherwise provided in 211 CMR 71.00 *et seq*., 211 CMR 71.00 *et seq*. shall apply to:

(a) All Medicare Supplement Insurance Policies offered, sold, issued, delivered, or otherwise made effective or renewed in Massachusetts on or after April 19, 1996;

(b) All Certificates issued under group Medicare Supplement Policies which Certificates have been offered, sold, issued, delivered or otherwise made effective or renewed in Massachusetts on or after April 19, 1996; and

(c) All Evidences of Coverage Issued Pursuant to a Risk or Cost Contract offered, sold, delivered, or otherwise made effective or renewed in Massachusetts on or after April 19, 1996; provided, however, that except as otherwise permitted or required under 211 CMR 71.03, 71.12(3) and 71.12(11), all Medicare Supplement Policies and Certificates originally issued to be effective prior to January 1, 1995 in compliance with 211 CMR 68.00 shall be guaranteed renewable and Issuers shall continue to renew all Medicare Supplement Policies and Certificates originally issued to be effective prior to July 30, 1992, if required under the terms and conditions of those Policies and Certificates; and provided, further, that Health Maintenance Organizations shall continue to renew Evidences of Coverage Issued Pursuant to a Risk or Cost Contract originally made effective prior to January 1, 1995, if required under the terms and conditions of those Evidences of Coverage.

(2) 211 CMR 71.00 shall not apply to a Policy, contract or Evidence of Coverage Issued Pursuant to a Risk or Cost Contract of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations.

(3) 211 CMR 71.00 *et seq*. supplements the rules of 211 CMR 40.00 through 42.00. In case of direct conflict between this and earlier regulations, 211 CMR 71.00 shall govern.

(4) 211 CMR 71.00 shall govern in case of direct conflict between 211 CMR 71.00 and 211 CMR 49.00, 211 CMR 64.00, 211 CMR 68.00, or 211 CMR 69.00.

71.03: Definitions

Actuarial Opinion: A signed written statement by a member of the American Academy of Actuaries based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods utilized by the Issuer in establishing premium rates for policies for Medicare Supplement Insurance or by a Health Maintenance Organization in establishing premium rates for Evidences of Coverage Issued Pursuant to a Cost Contract.

Advertisement: Advertisement shall include:

(a) Printed and published material, audio-visual material and descriptive literature of an Issuer used in direct mail, newspapers, magazines, radio scripts, television scripts, billboards and similar displays; and

(b) Descriptive literature and sales aids of all kinds issued by an Issuer, producer or other entity for presentation to members of the insurance-buying public including, but not limited to circulars, leaflets, booklets, depictions, illustrations, and form letters; and

(c) Prepared sales talks, presentations and material for use by producers (and solicitors).

Applicant: In the case of an individual Medicare Supplement Policy, the person who seeks to contract for insurance benefits, and in the case of a group Medicare Supplement Policy, the proposed certificateholder.

Bankruptcy: When a Medicare + Choice organization that is not an Issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in Massachusetts.

Benefit Level: The health benefits supplemental to Medicare provided by, and the benefit payment structure of, a Medicare Supplement Policy or Evidence of Coverage Issued Pursuant to a Risk or Cost Contract or other health benefit plan.

Biologically-based Mental Disorders: Those disorders that are described in M.G.L. c. 175, §47B(a), (b) and (c), M.G.L. c. 176A, §8A(a), (b), and (c), and M.G.L. c. 176B, §4A(a), (b) and (c), which are biologically-based, are rape-related or are adolescent/child mental disorders, for which benefits must be provided on a nondiscriminatory basis and that contain no annual or lifetime dollar or unit of service limitation on coverage for the diagnosis and treatment of mental disorders which is less than any annual or lifetime dollar or unit of service limitation imposed on coverage for the diagnosis and treatment of physical conditions.

Certificate: Any Certificate issued, renewed, delivered or issued for delivery in Massachusetts under a group Medicare Supplement Policy.

Certificate Form: The form on which the Certificate is issued, renewed, delivered or issued for delivery by the Issuer.

Class: The underwriting and rating classifications originally used at the time the Policy was issued.

Cold Lead Advertising: Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance producer or Issuer.

Commissioner: The Commissioner of Insurance or his or her designee.

Community Rating: A rating methodology in which the premium for all persons covered by a particular Medicare Supplement Insurance Policy or Evidence of Coverage Issued Pursuant to a Cost Contract is the same, based on the experience of all persons covered by the plan, without regard to age, sex, health status, or occupation.

Compensation: Includes pecuniary or non-pecuniary remuneration of any kind relating to the sale or renewal of the Medicare Supplement Insurance Policy including but not limited to commissions, bonuses, gifts, prizes, awards and finders' fees.

Division: The Division of Insurance.

Eligible Person: Any person who is eligible for Medicare Part A and B and is enrolled in Medicare Part B regardless of age; provided, however, that Issuers and Health Maintenance Organizations are not required to provide coverage to a person who is under the age of 65 and eligible for Medicare coverage due solely to end-stage renal disease; provided, further, that nothing in 211 CMR 71.00 *et seq*. prevents an Issuer or an HMO from providing coverage to a person who is under the age of 65 and is eligible for Medicare coverage due solely to end-stage renal disease; and provided, further, that if an Issuer or an HMO determines that it will provide coverage to people who are under the age of 65 and eligible for Medicare coverage due solely to end-stage renal disease, it shall do so in accordance with all of the provisions of 211 CMR 71.00 *et seq*. For the definition of eligible persons related to the federal Balanced Budget Act of 1997 (BBA Eligible Person), see 211 CMR 71.10(13)(a).

Employee Welfare Benefit Plan: A plan, fund or program of employee benefits as defined in 29 U.S.C. Section 1002 (Employee Retirement Income Security Act).

Evidence of Coverage: Any certificate, contract or agreement issued to a Member stating health services and benefits to which the Member is entitled as described in M.G.L. c. 176G, § 7 and M.G.L. c. 176K.

Evidence of Coverage Issued Pursuant to a Cost Contract: An Evidence of Coverage issued by a Health Maintenance Organization pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. Section 1395 *et seq*.) whereby Medicare makes payments to the Health Maintenance Organization on a reasonable cost basis, including health care prepayment plans, and M.G.L. c. 176G, § 7 and M.G.L. c. 176K.

Evidence of Coverage Issued Pursuant to a Risk or Cost Contract: An Evidence of Coverage issued by a Health Maintenance Organization pursuant to a contract under Section 1876 or Section 1833 or section 1859 of the federal Social Security Act (42 U.S.C. Section 1395 *et seq*.), including health care prepayment plans, and M.G.L. c. 176G, § 7 and M.G.L. c. 176K.

Group: An entity, as described in M.G.L. c. 175, § 110, to which a general or blanket Medicare Supplement Insurance Policy is issued or an entity to which a Medicare Supplement Insurance contract is issued pursuant to M.G.L. c. 176A, § 10 and M.G.L. c. 176B, § 4, except group shall not include one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations.

Guaranteed Renewable: A Policy provision whereby the Insured has the right to continue the Medicare Supplement Insurance Policy in force by the timely payment of premiums and the Issuer

has no unilateral right to make any change in any provision of the Policy or rider(s) while the insurance is in force other than changes in premiums, and cannot cancel or decline to renew, except for the non-payment of premium or material misrepresentation; provided that no Nonprofit Hospital Service Corporation or Medical Service Corporation shall be required to continue the coverage of a policyholder who becomes a resident of a state other than Massachusetts.

Health Maintenance Organization or HMO: An entity organized under M.G.L. c. 176G which offers, sells, issues, delivers, or otherwise makes effective, or renews in Massachusetts Evidences of Coverage Issued Pursuant to a Risk or Cost Contract.

High Pressure Tactics: Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

Individual: A person or family to which a Medicare Supplement Insurance Policy is issued pursuant to M.G.L. c. 175, § 108, or M.G.L. c. 176A, § 6 and M.G.L. c. 176B, § 4.

Initially Eligible for Coverage: The date when an Eligible Person first enrolled for benefits under Medicare Part B, lost employer-sponsored health coverage due to termination of employment or because of employer bankruptcy or because of discontinuance of employer-sponsored health coverage available to similarly situated employees by the employer**,** moved out of the service area of a Health Maintenance Organization, or became a resident of Massachusetts.

Insolvency: When an Issuer, licensed to transact the business of insurance in Massachusetts, has had a final order of liquidation entered against it with a finding of insolvency by a court of competent jurisdiction in the Issuer's state of domicile.

Insured: A subscriber, policyholder, member, enrollee or certificateholder under a Medicare Supplement Insurance Policy.

Issue: To offer, sell, issue, deliver, or otherwise make effective, or renew.

Issuer: Any company as defined in M.G.L. c. 175, § 1 and authorized to write accident and health insurance; any hospital service corporation as defined in M.G.L. c. 176A, § 1, any medical service corporation as defined in M.G.L. c. 176B, § 1 or any Fraternal Benefit Society as authorized in M.G.L. c. 176 which offers, sells, delivers or otherwise makes effective, or renews in Massachusetts Medicare Supplement Insurance Policies. Issuer shall not include Health Maintenance Organizations.

Late Enrollee: An Eligible Person who has submitted an application for a Medicare Supplement Insurance Policy after the six month period beginning with the first month in which the Eligible Person first enrolled for benefits under Medicare Part B, or lost employer-sponsored coverage due to termination of employment or because of employer bankruptcy or because of discontinuance of employer-sponsored health coverage by the employer, or became a resident of Massachusetts; provided, however, that an Eligible Person shall not be considered a Late Enrollee if the person was covered under a Reasonably Actuarially Equivalent previous health plan and the previous coverage was continuous for the lesser of three years or the period since first eligibility and to a date not more than 30 days prior to the effective date of the new coverage.

Medicare: "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

Medicare+Choice Plan: A plan of coverage for health benefits under Medicare Part C as defined in 42 U.S.C. 1395w-28(b)(1), and includes:

(1) Coordinated care plans which provide health care services, including but not limited to health maintenance organization plans (with or without a point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organization plans;

(2) Medical savings account plans coupled with a contribution into a Medicare+Choice medical savings account; and

(3) Medicare+Choice private fee-for-service plans.

Medicare Eligible Expense: Health care expenses of the kinds covered by Medicare, to the extent recognized as reasonable and medically necessary by Medicare.

Medicare Supplement Insurance or Policy: A type of health insurance which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare.

Member: Any person who has entered into a health maintenance contract, or on whose behalf such an arrangement has been made, with a Health Maintenance Organization for health services and any dependent of such person who is covered by the same contract.

Mental Disorder: A condition as described in the most recent edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.

OBRA 90: The federal Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508) and as this act is amended from time to time.

Off-label Use: A drug that has not been specifically approved by the United States Food and Drug Administration for the treatment of cancer or HIV/AIDS but is a drug approved for other indications by the Food and Drug Administration.

Other Mental Health Disorders: All other mental disorders described in the most recent edition of the DSM that are not biologically-based.

Outpatient Prescription Drug: A prescription drug that is administered on an outpatient basis.

Participate in the Market: To offer, sell, issue, deliver, or otherwise make effective, or renew, a Medicare Supplement Insurance Policy or Evidence of Coverage Issued Pursuant to a Risk or Cost Contract in Massachusetts, and to have not discontinued the availability of all of its Policy forms or Certificate forms or its Evidences of Coverage Issued Pursuant to a Risk or Cost Contract in Massachusetts.

Policy: Any Policy, Certificate, contract, agreement, statement of coverage, rider or endorsement issued by an Issuer as defined herein which provides Medicare Supplement Insurance as defined herein other than a Policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. Section 1395 *et seq*.) or an issued Policy under a demonstration project specified in 42 U.S.C. §. 1395ss(g)(1), which provides Medicare Supplement Insurance as defined herein.

Policy Form: The form on which the Medicare Supplement Insurance Policy is delivered or issued for delivery by the Issuer.

Pre-existing Conditions Limitation or Exclusion: A provision in a Medicare Supplement Insurance Policy or an Evidence of Coverage Issued Pursuant to a Risk or Cost Contract which limits or excludes coverage for charges or expenses incurred following the Insured's coverage effective date as to a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.

Producer: Any agent, broker, advisor or other person engaged in activities described in M.G.L. c. 175, §§ 162 through 177D.

Reasonably Actuarially Equivalent: The Benefit Level of one of two Medicare Supplement Policies or Evidences of Coverage Issued Pursuant to a Risk or Cost Contract or other health benefit plan being compared is no more than ten percentage points greater in value than the Benefit Level for the other Medicare Supplement Policy or Evidence of Coverage Issued Pursuant to a Risk or Cost Contract or health benefit plan, assuming that the benefits are offered to identical populations.

Risk or Cost Contract: A contract under Section 1876 or Section 1833 of the federal Social Security Act (42 U.S.C. Section 1395 *et seq*.), including health care prepayment plans.

Secretary: The Secretary of the United States Department of Health and Human Services.

Twisting: Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or carriers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance Policy or to take out a Policy of insurance with another carrier.

Upgrade Coverage: The Medicare Supplement Insurance Policy or Evidence of Coverage Issued Pursuant to a Risk or Cost Contract under which the Eligible Person is covered at the time of application for new coverage has a lower Benefit Level than the new coverage, and the two coverages are not Reasonably Actuarially Equivalent.

Waiting Period: A period immediately subsequent to the effective date of an Insured's coverage during which the insurance coverage does not pay for some or all hospital or medical expenses.

71.04: Readability Standards

(1) The text of all Policy forms not exempted under M.G.L. c. 175, § 2B must meet the requirements of M.G.L. c. 175, § 2B, including a minimum Flesch readability score of 50. All forms shall be written in clear and understandable English. When possible, technical terms must be avoided. If a technical term cannot be avoided, it must be defined at least one time.

(2) The text of all riders and endorsements to be used with such Policy forms shall separately achieve a Flesch score of 50 or higher. If such a form fails to meet this standard, an explanation must be given of why this standard cannot be met and the certification made pursuant to 211 CMR 71.12(9)(p) must indicate that such form, in conjunction with any other form or combinations of forms to which it will be attached, will achieve a score of 50 or higher.

71.05: Standards for Policy Definitions

(1) No Policy or Certificate may be advertised, solicited, issued, renewed, delivered or issued for delivery in Massachusetts as a Medicare Supplement Policy or Certificate unless such Policy or Certificate contains definitions or terms which conform to the requirements of 211 CMR 71.05.

(2) All definitions used in a Medicare Supplement Insurance Policy shall be compatible with Medicare definitions and practice.

(3) All Medicare Supplement Insurance policies shall include a definition for the following terms:

Accident, Accidental Injury, or Accidental Means shall be defined to employ "result" language and shall not include words which establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization.

(a) The definition shall not be more restrictive than the following: "Injury or injuries for which benefits are provided means accidental bodily injury sustained by the insured person which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force."

(b) The definition may provide that injuries shall not include injuries for which benefits are provided or available under any workers' compensation, employer's liability or similar law, motor vehicle no-fault plan, or other motor vehicle insurance related plan, unless prohibited by law.

Benefit Period or Medicare Benefit Period shall not be defined more restrictively than as defined in the Medicare program.

Convalescent Nursing Home, Extended Care Facility, or Skilled Nursing Facility shall not be defined more restrictively than as defined in the Medicare program. The definition must take into account that there are Policy benefits for these providers' services which are paid for only by the Medicare Supplement Policy and for which Medicare does not contribute payment.

Hospital may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals, but shall not be defined more restrictively than as defined in the Medicare program. The definition must take into account that there are Policy benefits for these providers' services which are paid for only by the Medicare Supplement Policy and for which Medicare does not contribute payment.

Medicare shall be defined in the Policy and Certificate. Medicare may be substantially defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended, or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof."

Medicare Eligible Expenses shall mean expenses of the kinds covered by Medicare, to the extent recognized as reasonable and medically necessary by Medicare.

Physician shall not be defined more restrictively than as defined in the Medicare program. The definition must take into account that there are Policy benefits for this provider's services which are paid for only by the Medicare Supplement Policy and for which Medicare does not contribute payment.

Sickness shall not be defined more restrictively than the following:

Sickness means illness or disease of an insured person for which expenses are incurred after the effective date of insurance and while the insurance is in force. The definition may be further modified to exclude sicknesses or diseases for which benefits are provided under any workers' compensation, occupational disease, employer's liability or similar law.

71.06: Policy Limitations

(1) No Medicare Supplement Insurance Policy shall be advertised, solicited, issued, renewed, delivered or issued for delivery which contains any waiting period or pre-existing condition limitation or exclusion.

(2) No Medicare Supplement Insurance Policy shall contain limitations or exclusions on coverage that are more restrictive than those of Medicare.

(3) Limitations on benefits shall be so labeled in a separate section of the Medicare Supplement Policy as well as placed with the benefit provisions to which they apply.

(4) No Medicare Supplement Insurance Policy shall contain benefits that duplicate benefits provided by Medicare.

71.07: Renewability

(1) Medicare Supplement Insurance Policies shall include a renewability provision. The language or specifications of the provision shall be consistent with the type of contract issued. Medicare Supplement Insurance Policies shall not contain renewal provisions less favorable to the Insured than "Guaranteed Renewable" as that term is defined in 211 CMR 71.03.

(2) All Medicare Supplement Insurance Policies shall contain a renewability provision as required by 211 CMR 71.07(1). Such provision shall be appropriately captioned and shall appear on the first page of the Policy and shall include any reservation by the Issuer of the right to change premiums.

(3) Medicare Supplement Insurance Policies shall comply with the following requirements:

(a) The Issuer shall not cancel or nonrenew the Policy solely on the ground of the health status of the individual.

(b) The Issuer shall not cancel or nonrenew the Policy for any reason other than nonpayment of premium or material misrepresentation; provided that no Nonprofit Hospital Service Corporation or Medical Service Corporation shall be required to continue the coverage of a policyholder who becomes a resident of a state other than Massachusetts.

(c) If the Medicare Supplement Insurance Policy is terminated by the group policyholder and is not replaced as provided under 211 CMR 71.07(3)(e), the Issuer shall offer certificateholders an individual Medicare Supplement Insurance Policy which, at the option of the certificateholder:

1. Provides for continuation of the benefits contained in the group Policy; or
2. Provides for benefits that otherwise meet the requirements of 211 CMR 71.07(3).

(d) If an individual is a certificateholder in a group Medicare Supplement Policy and the individual terminates membership in the group, the Issuer shall:

1. Offer the certificateholder the conversion opportunity described in 211 CMR 71.07(3)(c); or
2. At the option of the group policyholder, offer the certificateholder continuation of coverage under the group Policy.

(e) If a group Medicare Supplement Policy is replaced by another group Medicare Supplement Policy purchased by the same policyholder, the Issuer of the replacement policy shall offer coverage to all persons covered under the old group Policy on its date of termination. Coverage under the new Policy shall not contain any waiting period or preexisting condition limitation or exclusion.

(f) Termination of a Medicare Supplement Policy shall be without prejudice to any continuous loss which commenced while the Policy was in force, but the extension of benefits beyond the period during which the Policy was in force may be conditioned upon the continuous total disability of the Insured, limited to the duration of the Policy benefit period, if any, or payment of the maximum benefits.

(g) General Standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this regulation.

1. A Medicare Supplement Policy shall provide that benefits and premiums under the Policy or Certificate shall be suspended at the request of the policyholder or certificateholder for the period (not to exceed twenty-four months unless the Issuer permits a longer period of suspension) in which the policyholder or certificateholder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificateholder notifies the Issuer of such Policy or Certificate within 90 days after the date the individual becomes entitled to such assistance.

2. If suspension occurs and if the policyholder or certificateholder loses entitlement to medical assistance, the Policy or Certificate shall be automatically reinstituted (effective as of the date of termination of such entitlement) if the policyholder or certificateholder provides notice of loss of entitlement within 90 days after the date of loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

3. Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended (for any period that may be provided by federal regulation) at the request of the policyholder if the policyholder is entitled to benefits under Section 226(b) of the Social Security Act and is covered under a group health plan (as defined in Section 1862(b)(1)(A)(v) of the Social Security Act). If suspension occurs and if the policyholder or certificateholder loses coverage under the group health plan, the policy shall be automatically reinstituted (effective as of the date of loss of coverage) if the policyholder provides notice of loss of coverage within 90 days after the date of the loss.

4. Reinstitution of such coverages as described in 211 CMR 71.07(3)(g)(3 and 4):

   a. Shall not provide for any waiting period with respect to treatment of preexisting conditions;

   b. Shall provide for coverage which is substantially equivalent to coverage in effect before the date of such suspension; and

   c. Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificateholder as the premium classification terms that would have applied to the policyholder or certificateholder had the coverage not been suspended.

(4)(a) Issuers shall continue to renew Medicare Supplement Policies originally made effective prior to January 1, 1995 under the terms and conditions of those Policies, except as otherwise permitted or required under 211 CMR 71.03 and 71.12.

(b) Required Notice of Opportunity to Transfer to Community Rated Policy. Every Issuer which has issued a Medicare Supplement Policy to be effective prior to January 1, 1995 and has an existing policyholder of a Medicare Supplement Policy and renews an age-rated Medicare Supplement Policy on or after January 1, 1995 shall provide notice at the time of renewal to its policyholders of their right to transfer to a community rated Policy during the annual open enrollment periods held in February and March of calendar years

1995, 1996 and 1997 with coverage to begin June 1 of such calendar year without paying a surcharge in accordance with the provisions in 211 CMR 71.10(5).

71.08: Policy Benefit Standards

(1) A Medicare Supplement Insurance Policy shall not be advertised, solicited, delivered, issued, issued for delivery or renewed to be effective on or after January 1, 1995 unless the Policy meets the following requirements:

(a) A Medicare Supplement Policy shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(b) Any Medicare Supplement Insurance Policy shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors and any Medicare Supplement Insurance Policy issued to be effective on or after January 1, 1995 shall provide that benefits will be changed automatically to coincide with any changes required under Massachusetts law regarding mandated benefits; premiums may be modified to correspond with such changes, if approved by the Commissioner in accordance with statutory and regulatory requirements; provided, however, that such Policy shall provide that the Insured agrees to the change of benefits and premiums based on changes required under Massachusetts law regarding mandated benefits; and provided, further, that, except as otherwise required by law, all Medicare Supplement Policies and Certificates originally issued to be effective prior to January 1, 1995 shall maintain any guaranteed renewable fixed drug deductible and the same benefits covered in the original Policy.

(c) No Medicare Supplement Insurance Policy shall contain benefits that duplicate benefits provided by Medicare.

(d) No Medicare Supplement Insurance Policy shall contain any waiting period or pre-existing condition limitation or exclusion.

(e) No Medicare Supplement policy shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the Insured, other than the nonpayment of premium.

(f) Each Medicare Supplement Policy shall be guaranteed renewable in accordance with the provisions of 211 CMR 71.07.

(g) No Medicare Supplement Insurance Policy issued to be effective on or after January 1, 1995, which provides coverage for prescription drugs, shall exclude coverage of any such drug for the treatment of cancer or HIV/AIDS on the ground that the off-label use of the drug has not been approved by the United States Food and Drug Administration for that indication; provided, however, that such drug is recognized for treatment of such indication in one of the standard reference compendia; or in the medical literature, as those terms are defined in M.G.L. c. 175, § 47O, or by the Commissioner under the provisions of M.G.L. c. 175, § 47P.

(h) An Issuer of a Medicare Supplement Insurance Policy shall refund the unearned portion of any premium paid on a quarterly, semi-annual or annual basis upon the death of a policyholder. An Issuer of a Medicare Supplement Insurance Policy may refund the unearned portion of any premium paid on a quarterly, semi-annual or annual basis in the case of cancellation by the policyholder for reasons other than death. When calculating all such refunds, an Issuer of a Medicare Supplement Insurance Policy shall convert the billing mode from annual, semi-annual, or quarterly to monthly as of the date of death or cancellation by the policyholder for reasons other than death and refund the premium paid less the sum of the monthly premiums earned to that point or use a refund methodology submitted to and approved by the Commissioner. All Medicare Supplement Issuers shall notify applicants regarding premium refunds in the required outline of coverage as set forth in

211 CMR 71.13(2)(c)2. Nothing in 211 CMR 71.08(1)(h) shall affect the rights of a policyholder to return the policy within 30 days of its delivery and receive a premium refund pursuant to 211 CMR 71.13 (1)(e).

(2) For Medicare Supplement Insurance Policies issued to be effective on or after January 1, 1995, the following three Medicare Supplement options are mandatory as to standards and benefits and shall not be modified in any manner. No other Medicare Supplement options may be issued to be effective on or after January 1, 1995.

(a) Medicare Supplement Core. A Medicare Supplement Core Insurance Policy shall provide the coverage specified in 211 CMR 71.90: *Appendix A* and shall not provide any additional benefits.

(b) Medicare Supplement 1. A Medicare Supplement 1 Insurance Policy shall provide the coverage specified in 211 CMR 71.91: *Appendix B* and shall not provide any additional benefits.

(c) Medicare Supplement 2. A Medicare Supplement 2 Insurance Policy shall provide the coverage specified in 211 CMR 71.92: *Appendix C* and shall not provide any additional benefits.

(3) For Medicare Supplement Insurance Policies issued to be effective on or after January 1, 1995, an Issuer offering Medicare Supplement Insurance shall make available to each prospective policyholder and certificateholder a Policy form or Certificate form containing only Medicare Supplement Core Insurance benefits, in accordance with 211 CMR 71.08(2)(a), and a Policy form or Certificate form containing only Medicare Supplement 2 Insurance benefits, in accordance with 211 CMR 71.08(2)(c).

(4) No groups, packages or combinations of Medicare Supplement Insurance benefits other than those listed in 211 CMR 71.08(2) shall be offered for sale to be effective on or after January 1, 1995 in Massachusetts, except as may be permitted in 211 CMR 71.09.

(5) Benefit plans for Medicare Supplement Policies and Certificates issued to be effective on or after January 1, 1995 shall be uniform in structure, language, designation and format to the standard benefit plans listed in 211 CMR 71.08(2) and conform to the definitions in 211 CMR 71.03 and 71.05. Each benefit shall be structured in accordance with the format provided in 211 CMR 71.90, 71.91 and 71.92 and list the benefits in the order shown in the foregoing respective subsections. For purposes of 211 CMR 71.08, "structure, language, and format" means style, arrangement and overall content of a benefit.

(6) An Issuer of Medicare Supplement Insurance may use, in addition to the benefit plan designations required in 211 CMR 71.08(2), other designations or product names to the extent permitted by law.

(7) Every Issuer shall make available a Medicare Supplement Core Insurance Policy, as described in 211 CMR 71.08(2)(a) and Medicare Supplement 2 Insurance Policy, as described in 211 CMR 71.08(2)(c), to each prospective policyholder or certificateholder. An Issuer may make available to prospective Insureds any of the other Medicare Supplement Insurance benefit plans in addition to the Medicare Supplement Core and Medicare Supplement 2 packages, but not in lieu of them.

71.09: New or Innovative Benefits

(1) An Issuer of Medicare Supplement Insurance may, with the prior approval of the Commissioner, offer Medicare Supplement Policies or Certificates with new or innovative benefits described in 211 CMR 71.09(1) in addition to the benefits provided in a Policy or Certificate that otherwise complies with the applicable standards set forth in 211 CMR 71.00, *et seq*. The new or innovative benefits may include benefits that are appropriate to Medicare Supplement Insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner which is consistent with the goal of simplification of Medicare Supplement Insurance Policies. Only those new and innovative benefits specified in 211 CMR 71.09(1)(a) and (b), and any other new or innovative benefits approved by the Commissioner may be so offered.

(a) New Benefits.

Individual Case Management. Issuers providing Medicare Supplement Insurance may provide coverage for services in addition to the benefits required in 211 CMR 71.90, 71.91 or 71.92 as part of an individual case management program. Such program must be approved by the Commissioner in advance. Such individual case management program may be established by the Issuer pursuant to a plan of care agreed to by the Insured and the attending physician and approved under the Issuer's individual case management program.

(b) Innovative Benefits.

1. Outpatient Prescription Drug Benefits. In providing the Outpatient Prescription Drug benefits in a Medicare Supplement Policy or Certificate under 211 CMR 71.92(11) or as allowed by 211 CMR 71.09(2), an Issuer may limit benefits to those received from providers with whom it has an agreement, provided that such limitation does not significantly reduce the availability of benefits under the Policy; and provided, further, that any limitation or exclusion of a provider, and any such agreement, are in accordance with M.G.L. c. 176D, § 3B. For the purposes of 211 CMR 71.09(1)(b)1., "Outpatient Prescription Drugs" includes insulin, as well as the needles, syringes, pumps and pump supplies necessary for the administration of insulin and blood sugar level testing equipment supplies for use at home; drugs provided by a home infusion therapy provider; and drugs used on an off-label basis for the treatment of cancer or HIV/AIDS and medically necessary services associated with the administration of such drugs as required by M.G.L. c. 175, § 47K; M.G.L. c. 175, § 47L; M.G.L. c. 176A, § 8N; and M.G.L. c. 176B, § 4N, as amended from time to time, or by M.G.L. c. 175, § 47O; M.G.L. c. 175, § 47P; M.G.L. c. 176A, § 8O (as added by St. 1994, c. 60, § 144); or by M.G.L. c. 176B, § 4P (as added by St. 1994, c. 60, § 146), and drugs and devices for hormone replacement therapy for peri and post menopausal women and for outpatient prescription contraceptive drugs or devices as required by M.G.L. c. 175, § 47W; M.G.L. c. 176A, § 8W or M.G.L. c. 176B, § 4W (as added by St. 2002, c. 49).

2. Mail Service Prescription Drug Program. Issuers providing Medicare Supplement Insurance Policies or Certificates may provide coverage for a mail service prescription drug program for Outpatient Prescription Drugs for which federal law requires a prescription in addition to the benefits required by 211 CMR 71.92(11). The benefit must be approved by the Commissioner in advance; provided, however, that the Insured shall only be charged a copayment and the Insured's copayments for Outpatient Prescription Drugs shall be either 1) no higher than $8 for each generic prescription or refill and no higher than $15 for each brand name prescription or refill; or 2) no higher than $10 for each generic or brand name prescription or refill; and provided, further, that each such prescription or refill shall contain a minimum of 21 days' and a maximum of 90 days' supply. Nothing in 211 CMR 71.09(1)(b)2. shall be construed to prevent such an Issuer from basing payment on allowed charges rather than on charges or limiting benefits to those received from providers with whom they have an agreement; provided that such limitation does not significantly reduce the availability of benefits under the Policy; and provided, further, that any limitation or exclusion of a provider, and any such agreement,

are in accordance with M.G.L. c. 176D, § 3B. For the purposes of 211 CMR 71.09(1)(b)2., "Outpatient Prescription Drugs" includes insulin, as well as the needles, syringes, pumps and pump supplies necessary for the administration of insulin and blood sugar level testing equipment and supplies for use at home; drugs provided by a home infusion therapy provider; and drugs used on an off-label basis for the treatment of cancer or HIV/AIDS and medically necessary services associated with the administration of such drugs as required by M.G.L. c. 175, § 47K; M.G.L. c. 175, § 47L; M.G.L. c. 176A, § 8N; and M.G.L. c. 176B, § 4N, as amended from time to time, or by M.G.L. c. 175, § 47O; M.G.L. c. 175, § 47P; M.G.L. c. 176A, § 8O (as added by St. 1994, c. 60, § 144); or by M.G.L. c. 176B, § 4P (as added by St. 1994, c. 60, § 146), and drugs and devices for hormone replacement therapy for peri and post menopausal women and for outpatient prescription contraceptive drugs or devices as required by M.G.L. c. 175, § 47W; M.G.L. c. 176A, § 8W or M.G.L. c. 176B, § 4W (as added by St. 2002, c. 49, §§ 4 and 5).

(2)(a) Alternative Copayment Outpatient Prescription Drug Benefit. An Issuer of Medicare Supplement Insurance may, with the prior approval of the Commissioner, offer a separate Medicare Supplement Policy or Certificate form with the innovative benefit described in 211 CMR 71.09(2)(a) through (d) in replacement of the benefit described in 211 CMR 71.92(11); provided that the Policy or Certificate otherwise complies with the applicable standards set forth in 211 CMR 71.92, is offered only in addition to the Medicare Policy or Certificate form required in 211 CMR 71.92, and has a premium cost which is not higher than the form required in 211 CMR 71.92 and is not more than 10% lower than the premium cost for the form required in 211 CMR 71.92.

(b) Such innovative benefit shall contain the following benefits for Outpatient Prescription Drugs:

1. a copayment amount to be no higher than $8 for each generic prescription or refill and a copayment amount to be no higher than $15 for each brand name prescription or refill; or
2. a copayment amount to be no higher than $10 for each generic or brand name prescription or refill;

provided, however, that each such prescription or refill shall contain the lesser of the clinically appropriate supply for a spell of illness or a 90 days' supply.

(c) For the purposes of 211 CMR 71.09(2)(b), "Outpatient Prescription Drugs" includes insulin, as well as the needles, syringes, pumps and pump supplies necessary for the administration of insulin and blood sugar level testing equipment and supplies for use at home; drugs provided by a home infusion therapy provider; and drugs used on an off-label basis for the treatment of cancer or HIV/AIDS and medically necessary services associated with the administration of such drugs as required by M.G.L. c. 175, § 47K; M.G.L. c. 175, § 47L; M.G.L. c. 176A, § 8N; and M.G.L. c. 176B, § 4N, as amended from time to time, or by M.G.L. c. 175, § 47O; M.G.L. c. 175, § 47P; M.G.L. c. 176A, § 8O (as added by St. 1994, c. 60, § 144); or by M.G.L. c. 176B, § 4P (as added by St. 1994, c. 60, § 146), and drugs and devices for hormone replacement therapy for peri and post menopausal women and for outpatient prescription contraceptive drugs or devices as required by M.G.L. c. 175, § 47W, M.G.L. c. 176A, § 8W or M.G.L. c. 176B, § 4W (as added by St. 2002, c. 49, §§ 4 and 5).

(d) Nothing in 211 CMR 71.09(2) shall be construed to prevent such an Issuer from basing payment on allowed charges rather than on charges or limiting benefits to those received from providers with whom they have an agreement; provided that such limitation does not significantly reduce the availability of benefits under the Policy; and provided, further, that any limitation or exclusion of a provider, and any such agreement, are in accordance with M.G.L. c. 176D, § 3B.

71.10: Open Enrollment and Guarantee Issue for Medicare Supplement Insurance and Evidences of Coverage Issued Pursuant to a Risk or Cost Contract

(1) No Issuer participating in the market for Medicare Supplement Insurance and no Health Maintenance Organization participating in the market for Evidences of Coverage Issued Pursuant to a Risk or Cost Contract shall, at any time on or after January 1, 1995, deny or condition the issuance of any Medicare Supplement Insurance Policy or Evidence of Coverage Issued Pursuant to a Risk or Cost Contract for sale in Massachusetts, nor discriminate in the pricing of such a plan, to any Eligible Person because of the age, health status, claims experience, receipt of health care, or medical condition of the Eligible Person.

(2) No Medicare Supplement Insurance Policy or Evidence of Coverage Issued Pursuant to a Risk or Cost Contract may contain any waiting period or pre-existing condition limitation or exclusion.

(3) Required Part B Open Enrollment Period. An Issuer of Medicare Supplement Insurance shall not deny or condition the issuance or effectiveness of any Medicare Supplement Policy or Certificate available for sale in Massachusetts, nor discriminate in the pricing of such a Policy or Certificate because of the health status, claims experience, receipt of health care, or medical condition of an Applicant in the case of an application for a Policy or Certificate that is submitted prior to or during the six month period beginning with the first day of the first month in which an individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B. Each Medicare Supplement Policy and Certificate currently available from an Issuer shall be made available to all Applicants who qualify under 211 CMR 71.10(3), except as provided in 211 CMR 71.10(11).

(4) Required Open Enrollment Period for Those Initially Eligible for Coverage. An Issuer participating in the market for Medicare Supplement Insurance and a Health Maintenance Organization participating in the market for Evidences of Coverage Issued Pursuant to a Risk or Cost Contract shall not deny or condition the issuance or effectiveness of any Medicare Supplement Insurance Policy or Certificate or Evidence of Coverage Issued Pursuant to a Risk or Cost Contract, nor discriminate in the pricing of such Policy or Certificate or Evidence of Coverage Issued Pursuant to a Risk or Cost Contract, to an Eligible Person in the case of an application of such Policy or Certificate or Evidence of Coverage Issued Pursuant to a Risk or Cost Contract that is submitted prior to or during the six month period beginning with the first day of the first month in which the Eligible Person became Initially Eligible for Coverage. Each Medicare Supplement Policy and Certificate or Evidence of Coverage Issued Pursuant to a Risk or Cost Contract currently available from the Issuer or Health Maintenance Organization shall be made available to all Eligible Persons who qualify under 211 CMR 71.10(4), except as provided in 211 CMR 71.10(10) and (11).

(5) Required Annual Open Enrollment Period.

(a) Every Issuer participating in the market for Medicare Supplement Insurance and every Health Maintenance Organization participating in the market for Evidences of Coverage Issued Pursuant to a Risk or Cost Contract shall make available during the required annual open enrollment period to every Eligible Person each Medicare Supplement Policy and Certificate or Evidence of Coverage currently available from the Issuer or Health Maintenance Organization for whom an application for such Policy is submitted during the required annual open enrollment period by the Eligible Person except as provided in 211 CMR 71.10(10) and (11). The required annual open enrollment period for Eligible Persons shall commence on February first and end on March thirty-first of each year, for coverage to be effective June first of that year or no later than when Medicare coverage is first effective, whichever is earlier.

(b) For the required annual open enrollment periods to be held during calendar years 1995 and 1996, no surcharge as described in 211 CMR 71.20 may be applied against the premium charged to an Eligible Person who is a Late Enrollee or who Upgrades Coverage.

(c) For the required annual open enrollment periods to be held during calendar years 1995, 1996 and 1997, no surcharge may be applied against the premium charged to an Eligible Person who Upgrades Coverage if such eligible person who Upgrades Coverage is upgrading from a Medicare Supplement Insurance Policy or Evidence of Coverage Issued Pursuant to a Risk or Cost Contract which was issued to be effective prior to January 1, 1995.

(d) For the required annual open enrollment periods to be held during calendar years 1995, 1996 and 1997, every Issuer participating in the market for Medicare Supplement Insurance and every Health Maintenance Organization participating in the market for Evidences of Coverage Issued Pursuant to a Risk or Cost Contract shall provide its Insureds or Members with written notice no later than January 1 of each such calendar year which provides, at least, the following information in easy to understand language:

1. an explanation of the existence of the annual open enrollment period which will be held during February and March of that year, the deadline of March 31 for applications, and effective date for new coverage of June 1 of that year;

2. notification that the Insured or Member may request a list of all Issuers which have available Medicare Supplement Policy forms and all Health Maintenance Organizations which have available Evidences of Coverage Issued Pursuant to a Risk or Cost Contract as of January 1 of that calendar year by contacting the Massachusetts Division of Insurance at [insert the address of the Massachusetts Division of Insurance], telephone number [insert the telephone number of the consumer helpline at the Massachusetts Division of Insurance]; or the Executive Office of Elder Affairs[insert the address of the Massachusetts Executive Office of Elder Affairs], telephone number [insert the toll-free number of the Massachusetts Executive Office of Elder Affairs];

3. an explanation that there will be no surcharge applied against the premium charged by any Issuer or Health Maintenance Organization of an Eligible Person who is a Late Enrollee or who Upgrades Coverage during the required annual open enrollment period held in calendar year 1995.

4. an explanation that there will be no surcharge applied against the premium of an Eligible Person who Upgrades Coverage if such Eligible Person who Upgrades Coverage is upgrading from a Medicare Supplement Insurance Policy or Evidence of Coverage Issued Pursuant to a Risk or Cost Contract which was issued to be effective prior to January 1, 1995.

(e) Any Health Maintenance Organization which obtains a waiver from the Commissioner pursuant to 211 CMR 71.23(5)(g), shall hold a special open enrollment period at the time the waiver has expired. Such special open enrollment period shall conform to the requirements of the required annual open enrollment period for calendar years 1995, 1996 and 1997 set forth in 211 CMR 71.10(5), except those pertaining to the starting date for the open enrollment period, subject to the Commissioner's approval.

(6) Required Open Enrollment Period Due to Termination of HMO Contract With Medicare. In the event that a Health Maintenance Organization's risk or cost contract with Medicare has been terminated, during an open enrollment period scheduled and authorized by the Commissioner, every Issuer participating in the market for Medicare Supplement Insurance and every Health Maintenance Organization participating in the market for Evidences of Coverage Issued Pursuant to a Risk or Cost Contract shall make available to every Eligible Person each Medicare Supplement Policy and Certificate or Evidence of Coverage currently available from the Issuer or Health Maintenance Organization if the Eligible Person's Evidence of Coverage Issued Pursuant to a Risk or Cost Contract was canceled or not renewed because the Health Maintenance

Organization's contract with Medicare has been terminated, except as provided in 211 CMR 71.10(10) and (11). Such coverage shall comply with all the provisions of 211 CMR 71.00, *et seq*. and shall become effective on the date that coverage under the risk or cost contract ends. The Commissioner will notify all Issuers and Health Maintenance Organizations subject to 211 CMR 71.10(6) of the time period for the open enrollment period described in 211 CMR 71.10(6) as soon as practicable. The length of the open enrollment period under 211 CMR 71.10(6) shall be set by the Commissioner as he or she deems to be warranted to ensure that all Applicants have a reasonable opportunity to obtain coverage.

(7) Required Open Enrollment Period Established under Administrative Supervision of an Issuer or a Health Maintenance Organization. In the event that the Commissioner assumes administrative supervision of an Issuer or a Health Maintenance Organization in accordance with M.G.L. c. 175J, and he or she orders the Issuer or HMO to reduce, suspend or limit the volume of business being accepted or renewed, including Medicare Supplement Insurance or Evidences of Coverage Issued Pursuant to a Risk or Cost Contract, during an open enrollment period scheduled and authorized by the Commissioner, every Issuer participating in the market for Medicare Supplement Insurance and every Health Maintenance Organization participating in the market for Evidences of Coverage Issued Pursuant to a Risk or Cost Contract shall make available to every Eligible Person each Medicare Supplement Policy and Certificate or Evidence of Coverage currently available from the Issuer or Health Maintenance Organization if the Eligible Person's Policy or Evidence of Coverage Issued Pursuant to a Risk or Cost Contract was canceled or not renewed in compliance with the Commissioner's order in accordance with 211 CMR 71.10(7), except as provided in 211 CMR 71.10(10) and (11). Such coverage shall comply with all the provisions of 211 CMR 71.00, *et seq*. and shall become effective on the date that coverage under the risk or cost contract ends. The Commissioner will notify all Issuers and Health Maintenance Organizations subject to 211 CMR 71.10(7) of the time period for the open enrollment period described in 211 CMR 71.10(7) as soon as practicable. The length of the open enrollment period under 211 CMR 71.10(7) shall be set by the Commissioner as he or she deems to be warranted to ensure that all Applicants have a reasonable opportunity to obtain coverage.

In the event of the placing of an Issuer or Health Maintenance Organization in administrative supervision, conservation, rehabilitation, reorganization, liquidation or any other similar proceeding by a governmental or public authority, the Commissioner may also establish an open enrollment period as provided in 211 CMR 71.10(7) to provide for the availability of coverage for every Eligible Person whose Medicare Supplement Insurance Policy or Evidence of Coverage Issued Pursuant to a Risk or Cost Contract is canceled or not renewed by reason of such a rehabilitation, reorganization or liquidation.

(8) Optional Periodic Open Enrollment Periods. In addition to the required open enrollment periods outlined in 211 CMR 71.10(3), (4), (5), (6) and (7), Issuers and Health Maintenance Organizations may hold additional open enrollment periods at other times of the year for Eligible Persons provided that each such open enrollment period is of a length of time of not less than 60 consecutive days. Each Issuer or Health Maintenance Organization electing to schedule open enrollment periods under 211 CMR 71.10(8) shall file a statement with the Commissioner describing the beginning and ending dates for the Issuer's or Health Maintenance Organization's open enrollment periods. Any open enrollment period held under 211 CMR 71.10(8) must comply with all of the requirements of 211 CMR 71.00, *et seq*. Each Medicare Supplement Policy and Certificate or Evidence of Coverage currently available from the Issuer or Health Maintenance Organization shall be made available to all Eligible Persons who submit applications during the open enrollment periods held under 211 CMR 71.10(8) except as provided in 211 CMR 71.10(10) and (11).

(9) Optional Continuous Open Enrollment. In addition to the required open enrollment periods outlined in 211 CMR 71.10(3), (4), (5), (6) and (7), Issuers and Health Maintenance Organizations may elect to maintain continuous open enrollment for Eligible Persons. Each Issuer or Health Maintenance Organization electing to schedule continuous open enrollment under 211 CMR 71.10(9) shall file a statement with the Commissioner describing the beginning date for the Issuer's or Health Maintenance Organization's continuous open enrollment. Such statement must be filed with the Commissioner at least 30 days prior to the beginning of such continuous open enrollment. Any Issuer or Health Maintenance Organization which chooses to cease continuous open enrollment under 211 CMR 71.10(9) shall notify the Commissioner in writing at least 60 days prior to the ending date for such continuous open enrollment. Each Issuer or Health Maintenance Organization shall provide at least 30 days' notice of such open enrollment period and any termination of the open enrollment period to its Insureds or Members. Any continuous open enrollment held under 211 CMR 71.10(9) must comply with all of the requirements of 211 CMR 71.00, *et seq*. Each Medicare Supplement Policy and Certificate or Evidence of Coverage currently available from the Issuer or Health Maintenance Organization shall be made available to all Eligible Persons who submit applications during the continuous open enrollment held under 211 CMR 71.10(9), except as provided in 211 CMR 71.10(10) and (11).

(10) Notwithstanding the provisions in 211 CMR 71.10(1), (4), (5), (6), (7), (8) and (9), any Health Maintenance Organization participating in the market for Evidences of Coverage Issued Pursuant to a Risk or Cost Contract shall not be required to accept applications from and offer coverage to Eligible Persons and persons who are Initially Eligible for Coverage if the Health Maintenance Organization is prohibited from accepting the application or is authorized to reject the application according to the requirements set forth in Section 1876 and Section 1833 of the federal Social Security Act (42 U.S.C. 1395, *et seq*.) and the regulations promulgated thereunder. When implementing an optional periodic open enrollment period pursuant to 211 CMR 71.10(8) or an optional continuous open enrollment period pursuant to 211 CMR 71.10(9), a Health Maintenance Organization is permitted to limit the time period during which its own Member, who is covered under such Health Maintenance Organization's Evidence of Coverage Issued Pursuant to a Risk or Cost Contract that does not contain outpatient prescription drug benefits, may enroll in its Evidence of Coverage Issued Pursuant to a Risk or Cost Contract that does contain outpatient prescription drug benefits, pursuant to Medicare HMO/CMP Regional Bulletin No. 95-1 issued by the Health Care Financing Administration of the federal government, provided, however that such Health Maintenance Organization must make available each of its Evidences of Coverage Issued Pursuant to a Risk or Cost Contract to its Members during February and March of each year pursuant to 211 CMR 71.10(5).

(11) Notwithstanding the provisions in 211 CMR 71.10(3) through (9), an Issuer participating in the market for Medicare Supplement Insurance that only has available Certificate forms for issuance in Massachusetts which are issued under one or more group Medicare Supplement Policies, and does not have available Medicare Supplement Policy forms for issuance to individuals in Massachusetts, shall not be required to issue a Medicare Supplement Policy to an Eligible Person who is not a member and is not eligible to be a member of the group or groups to which the Issuer has issued the group Medicare Supplement Policy or Policies; provided, however, that requirements to become a member in the group or groups are not based on health status, claims experience, receipt of health care or medical condition.

(12) Required Open Enrollment Period Due to Entry into Market. In the event that during the months of February through November an Issuer enters the market for Medicare Supplement Insurance or a Health Maintenance Organization enters the market for Evidences of Coverage Issued Pursuant to a Risk or Cost Contract, and is unable to participate in the full two-month

required annual open enrollment period specified in 211 CMR 71.10(5) held during the calendar year of the entry into the market, the Issuer or Health Maintenance Organization shall hold a special open enrollment period upon entry into the market. Such special open enrollment period shall conform to the requirements of the required annual open enrollment period for calendar years 1995, 1996 and 1997 set forth in 211 CMR 71.10(5), except those pertaining to the starting date for the open enrollment period, subject to the Commissioner's approval. For the purposes of 211 CMR 71.10(12), "enters the market" shall mean that the Issuer or Health Maintenance Organization is offering, selling, issuing, delivering, or otherwise making effective a Medicare Supplement Insurance Policy or Evidence of Coverage Issued Pursuant to a Risk or Cost Contract in Massachusetts in compliance with 211 CMR 71.00 *et seq*. either (a) for the first time on or after February 1, 1995 or (b) upon re-entry into the market in accordance with 211 CMR 71.22(3).

(13) Guaranteed Issue for Eligible Persons Under Section 4031 of the federal Balanced Budget Act of 1997, Section 501(a)(1) of the federal Balanced Budget Refinement Act of 1999 and Benefit Improvement and Patient Protection Act of 2000.

(a) Guaranteed Issue.

1. An Eligible Person, as defined by 211 CMR 71.03, who is an eligible person under Section 4031 of the federal Balanced Budget Act of 1997 (BBA Eligible Person) and Section 501 (a)(2) of the federal Balanced Budget Refinement Act of 1999, are those individuals described in 211 CMR 71.10(13)(b), who seek to enroll under the policy during the period specified in 211 CMR 71.10(13)(c) and who submit evidence of the date of termination or disenrollment with the application for a Medicare Supplement Policy.

2. With respect to BBA Eligible Persons, an issuer shall not deny or condition the issuance or effectiveness of a Medicare Supplement policy described in 211 CMR 71.10(13)(e) that is offered and is available for issuance to new enrollees by the issuer, shall not discriminate in the pricing of such a Medicare Supplement Policy because of health status, claims experience, receipt of health care, or medical condition, and shall not impose an exclusion of benefits based on a preexisting condition under such a Medicare Supplement Policy.

3. If a BBA Eligible Person also meets the requirements of being Initially Eligible for Coverage, as defined in 211 CMR 71.03, the individual shall be entitled to guarantee issue of all plans currently available from an Issuer as specified in 211 CMR 71.10(4), including the time periods specified.

(b) BBA Eligible Person.

A BBA Eligible Person is an individual who meets the definition of Eligible Person found in 211 CMR 71.03 and who is described in any of the following paragraphs:

1. The individual is enrolled under an Employee Welfare Benefit Plan that provides health benefits that supplement the benefits under Medicare; and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual;

2. The individual is enrolled with a Medicare+Choice organization under a Medicare+Choice plan under part C of Medicare, and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a Program of All Inclusive Care for the Elderly (PACE) provider under Section 1894 of the Social Security Act, and there are circumstances similar to those described below that would permit discontinuance of the individual's enrollment with such provider if such individual were enrolled in a Medicare+Choice plan:

i. The certification of the organization or plan under this part has been terminated; or

ii. The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;

iii. The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual's enrollment on the basis described in section 1851(g)(3)(B) of the federal Social Security Act (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under section 1856), or the plan is terminated for all individuals within a residence area;

iv. The individual demonstrates, in accordance with guidelines established by the Secretary, that:

I. The organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or

II. The organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or

v. The individual meets such other exceptional conditions as the Secretary may provide.

3.a. The individual is enrolled with:

i. An eligible organization under a contract under Section 1876 of the federal Social Security Act (Medicare cost);

ii. A similar organization operating under demonstration project authority, effective for periods before April 1, 1999;

iii. An organization under an agreement under Section 1833(a)(1)(A) of the federal Social Security Act (health care prepayment plan); or

iv. An organization under a Medicare Select policy; and

b. The enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under 211 CMR 71.10(13)(b)2.

4. The individual is enrolled under a Medicare Supplement Policy and the enrollment ceases because:

a. i. Of the insolvency of the Issuer or bankruptcy of the nonissuer organization; or

ii. Of other involuntary termination of coverage or enrollment under the policy;

b. The Issuer of the policy substantially violated a material provision of the policy; or

c. The Issuer, or an agent or other entity acting on the Issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual;

5. a. The individual was enrolled under a Medicare Supplement Policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare+Choice organization under a Medicare+Choice plan under part C of Medicare, any eligible organization under a contract under Section 1876 (Medicare cost), any similar organization operating under demonstration project authority, any PACE provider under Section 1894 of the Social Security Act or a Medicare Select policy; and

b. The subsequent enrollment under 211 CMR 71.10(13)(b)5.a. is terminated by the

enrollee during any period within the first twelve (12) months of such subsequent enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under Section 1851(e) of the federal Social Security Act);

6. The individual, upon first becoming eligible for benefits under part A of Medicare at age 65, enrolls in a Medicare+Choice plan under part C of Medicare or in a PACE program under Section 1894, and disenrolls from the plan or program by not later than 12 months after the effective date of enrollment.

(c) Guaranteed issue time periods

1. In the case of an individual as described in 211 CMR 71.10(13)(b)1, the guaranteed issue period begins on the date of the individual receives a notice of termination or cessation of all supplemental health benefits (or, if such notice is not received, notice that a claim has been denied because of such a termination or cessation) and ends 63 days after the date of the applicable notice;

2. in the case of an individual described in subsection in 211 CMR 71.10(13)(b)2., 3.,5.a., or 5.b. whose enrollment is terminated involuntarily , the guaranteed issue period begins on the date that the individual receives a notice of termination and ends 63 days after the date the applicable coverage is terminated;

3. In the case of an individual described in subsection in 211 CMR 71.10(13)(b)4.a., the g, the guaranteed issue period begins on the earlier of : (i) the date that the individual receives a notice of termination, a notice of the issuers bankruptcy or insolvency, or other such similar notice, if any, and (ii) the date that the applicable coverage is terminated, and ends 63 days after the coverage is terminated;

4. In the case of an individual described in subsection in 211 CMR 71.10(13)(b)2., 4.b., 4.c., 5.a. or 5.b. who disenrolls voluntarily, the guaranteed issue period begins on the date that is 60 days before the effective date of the disenrollment and ends 63 days after the effective date; and

5. In the case of an individual described in 211 CMR 71.10(13)(b) but not described in the preceding provisions of 211 CMR 71.10(13)(c), the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is 63 days after the effective date.

(d) Extended Medigap access for interrupted trial periods

1. In the case of an individual described in 211 CMR 71.10(13)(b)5. (or deemed to be so described, pursuant to 211 CMR 71.10(13)(d)) whose enrollment with an organization or provider described in 211 CMR 71.10(13)(b)5.a. involuntarily terminated within the first 12 months of enrollment, and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment shall be deemed to be an initial enrollment described in 211 CMR 71.10(13)(b)5.

2. in the case of an individual described in 211 CMR 71.10(13)(b)6. (or deemed to be so described, pursuant to 211 CMR 71.10(13)(d)) whose enrollment with a plan or in a program described in 211 CMR 71.10(13)(b)6. is involuntarily terminated within the first 12 months of enrollment, and who, without an intervening enrollment, enrolls in another plan or program, the subsequent enrollment shall be deemed to be an initial enrollment described in 211 CMR 71.10(13)(b)5.b.

3. For purposes of 211 CMR 71.10(13)(b)5. and 6. no enrollment of an individual with a organization or provider described in 211 CMR 71.10(13)(b)5.a., or with a plan or in a

program described in 211 CMR71.10(13)(b)6., may be deemed to be an initial enrollment under this paragraph after the 2-year period beginning on the date on which the individual first enrolled with such organization, provider, plan, or program.

(e) Products to Which BBA Eligible Persons are Entitled

The Medicare Supplement Policy to which BBA eligible persons are entitled under:

1. 211 CMR 71.10(13)(b)1., 2., 3. and 4. is a Medicare Supplement Core policy or a Medicare Supplement 1 policy offered by any Issuer.

2. 211 CMR 71.10(13)(b)5. is the same Medicare Supplement Policy in which the individual was most recently previously enrolled, if available from the same Issuer, or, if not so available, a policy described in 211 CMR 71.10(13)(e)1.

3. 211 CMR 71.10(13)(b)6. shall include any Medicare Supplement Policy offered by any Issuer.

(f) Notification provisions.

1. At the time of an event described in 211 CMR 71.10(13)(b) because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the Issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under 211 CMR 71.10(13), and of the obligations of issuers of Medicare Supplement Policies under 211 CMR 71.10(13)(a). Such notice shall be communicated contemporaneously with the notification of termination.

2. At the time of an event described in 211 CMR 71.10(13)(b) because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the Issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement policies under 211 CMR 71.10(13)(a). Such notice shall be communicated within ten working days of the Issuer receiving notification of disenrollment.

71.11: Standards for Claims Payment

(1) An Issuer of Medicare Supplement Insurance shall comply with section 1882(c)(3) of the Social Security Act (as enacted by section 4081(b)(2)(C) of the Omnibus Budget Reconciliation Act of 1987 (OBRA) 1987, Pub. L. No. 100-203) by:

(a) Accepting a notice from a Medicare carrier on dually assigned claims submitted by participating physicians and suppliers as a claim for benefits in place of any other claim form otherwise required and making a payment determination on the basis of the information contained in that notice;

(b) Notifying the participating physician or supplier and the beneficiary of the payment determination;

(c) Paying the participating physician or supplier directly;

(d) Furnishing, at the time of enrollment, each enrollee with a card listing the Policy name, number and a central mailing address to which notices from a Medicare carrier may be sent;

(e) Paying user fees for claim notices that are transmitted electronically or otherwise; and
(f) Providing to the Secretary of Health and Human Services, at least annually, a central mailing address to which all claims may be sent by Medicare carriers.

(2) Compliance with the requirements set forth in 211 CMR 71.11(1) shall be certified on the Medicare Supplement Insurance experience reporting form.

71.12: Policy Filings for Medicare Supplement Insurance and Rate Review for Medicare Supplement Insurance and Evidences of Coverage Issued Pursuant to a Cost Contract

(1) (a) An Issuer shall not offer, sell, deliver or issue for delivery, or otherwise make effective, or renew a Medicare Supplement Insurance Policy or Certificate described in 211 CMR 71.08(2) to a resident of Massachusetts unless the Policy form or Certificate form has been filed with and approved by the Commissioner in accordance with 211 CMR 71.12(9).

(b) An Issuer shall not offer, sell, deliver or issue for delivery, or otherwise make effective, or renew a Medicare Supplement Insurance Policy or Certificate defined in 211 CMR 71.08(2) to a resident of Massachusetts unless the rates therefor have been filed with and approved by the Commissioner in accordance with 211 CMR 71.12(11), (12), (15), (16) and (17).

(c) An Issuer shall not use or change premium rates for a Medicare Supplement Policy or Certificate defined in 211 CMR 71.08(2) and issued in accordance with the provisions of 211 CMR 71.12, unless the rates use a Community Rating method which has been approved by the Commissioner.

(d) An Issuer shall not use or change premium rates for a Medicare Supplement Policy or Certificate defined in 211 CMR 71.08(2) unless the rates, rating schedule and supporting documentation have been filed with and approved by the Commissioner in accordance with the filing requirements and procedures prescribed in 211 CMR 71.12(11), (12), (15), (16) and (17).

(2) On or after January 1, 1995, an Issuer shall not change premium rates for a Medicare Supplement Policy or Certificate originally issued to be effective prior to January 1, 1995 unless the rates, rating schedule and supporting documentation have been filed with and approved by the Commissioner in accordance with the filing requirements and procedures prescribed in 211 CMR 71.12(11), (12), (15), (16) and (17).

(3) An Issuer may use a Community Rating method to rate a Medicare Supplement Insurance Policy or Certificate originally issued to be effective prior to January 1, 1995 subject to the prohibition against altering contractual terms as provided in M.G.L. c. 176K, § 9.

(4) (a) On or after January 1, 1995, a Health Maintenance Organization shall not offer, sell, deliver or issue for delivery, or otherwise make effective, or renew an Evidence of Coverage Issued Pursuant to a Cost Contract to a resident of Massachusetts originally issued to be effective on or after January 1, 1995 unless the Evidence of Coverage Issued Pursuant to a Cost Contract form has been filed with the Commissioner in accordance with 211 CMR 71.12(11)(b)4., and the rates therefor have been filed with and, where applicable, approved by the Commissioner in accordance with 211 CMR 71.12(11), (12), (15), (16) and (17).

(b) On or after January 1, 1995, a Health Maintenance Organization shall not use or change premium rates for an Evidence of Coverage Issued Pursuant to a Cost Contract to a resident of Massachusetts originally issued to be effective prior to January 1, 1995 unless the Evidence of Coverage Issued Pursuant to a Cost Contract form has been filed with the Commissioner in accordance with 211 CMR 71.12(11)(b)4., and the rates therefor have

been filed with and, where applicable, approved by the Commissioner in accordance with 211 CMR 71.12(11), (12), (15), (16) and (17).

(c) A Health Maintenance Organization shall not use or change premium rates for an Evidence of Coverage Issued Pursuant to a Cost Contract and issued in accordance with the provisions of 211 CMR 71.12, unless the rates use a Community Rating method which has been approved by the Commissioner.

(5) (a) Except as provided in 211 CMR 71.12(5)(b), an Issuer shall not file for approval more than one form of a Policy or Certificate of each type for each standard Medicare Supplement benefit plan.

(b) An Issuer may offer, with the approval of the Commissioner, except where otherwise prohibited by statute, up to two additional Policy forms or Certificate forms of the same type for the same standard Medicare Supplement benefit plan, one for each of the following cases:

1. The inclusion of new or innovative benefits;
2. The addition of either direct response or agent marketing methods.

(c) For the purposes of 211 CMR 71.12, a "type" means an individual Medicare supplement Policy or a group Policy.

(6) Except as provided in 211 CMR 71.12(6)(a), an Issuer shall continue to make available for purchase any Medicare Supplement Policy form or Certificate form issued on or after January 1, 1995 that has been approved by the Commissioner. A Policy form or Certificate form shall not be considered to be available for purchase unless the Issuer has actively offered it for sale in the previous 12 months.

(a) Subject to the requirements of 211 CMR 71.08(3), an Issuer may discontinue the availability of a Medicare Supplement Policy form or Certificate form if the Issuer provides to the Commissioner in writing its decision at least 30 days prior to discontinuing the availability of the form of the Policy or Certificate. After receipt of the notice by the Commissioner, the Issuer shall no longer offer for sale the Policy form or Certificate form in Massachusetts. Nothing in 211 CMR 71.12(6) shall relieve an Issuer from the requirements of 211 CMR 71.22.

(b) An Issuer that discontinues the availability of a Medicare Supplement Policy form or Certificate form pursuant to 211 CMR 71.12 (6)(a) shall not file for approval a new Policy form or Certificate form of the same type for the same standard Medicare Supplement benefit plan as the discontinued form for a period of five years after the Issuer provides notice to the Commissioner of the discontinuance. The period of discontinuance may be reduced if the Commissioner determines that a shorter period is appropriate.

(c) The sale or other transfer of Medicare Supplement business to another Issuer shall be considered a discontinuance for the purposes of 211 CMR 71.12(6).

(d) A change in the rating structure or methodology shall be considered a discontinuance under 211 CMR 71.12(6)(a) and (b) unless the Issuer complies with the following requirements:

1. The Issuer provides an actuarial memorandum, in a form and manner prescribed by the Commissioner, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and existing rates.
2. The Issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The Commissioner may approve a change to the differential that is in the public interest.

(7) Except as provided in 211 CMR 71.12(6)(c), the experience of all Policy forms or Certificate forms of the same type in a standard Medicare Supplement benefit plan issued on or after July 30, 1992, and the experience of all Medicare Supplement Policy forms or Certificate forms providing substantially the same coverage issued prior to July 30, 1992, shall be combined for purposes of the refund or credit calculation prescribed in 211 CMR 71.12(13).

(8) Forms assumed under an assumption reinsurance agreement shall not be combined with the experience of other forms for purposes of the refund or credit calculation.

(9) Medicare Supplement Policy Forms.

(a) All submissions shall be submitted in triplicate, unless otherwise permitted by the Commissioner and are to be addressed to the Massachusetts Division of Insurance, Policy Review Section.-The Issuer shall also provide a copy of all materials on a 3.5" floppy disk readable in IBM format, ASCII only, or other form specified by the Commissioner, unless granted a waiver from this requirement by the Division.

(b) The statutory filing fee shall accompany each form submitted each time it is submitted, whether for preliminary or final review. Payment shall be by check payable to the "Commonwealth of Massachusetts, Division of Insurance."

(c) Each submission shall be accompanied by Massachusetts Division of Insurance Life and Accident & Health Forms, Form SRB-CH1, Transmittal Letter/Information Checklist.

(d) To facilitate prompt replies, Issuers shall either enclose with each submission a stamped, addressed return envelope of appropriate size or otherwise provide for return communication from the Division.

(e) Each form submitted for final approval must be printed, be a printer's proof, or be in the form in which it will be issued.

(f) Any form in which the printed text has been altered will not be accepted for review or final approval.

(g) Each form shall display an identification code not to exceed 13 spaces on the lower left-hand corner of the first page.

(h) The cover letter shall be submitted in triplicate, unless otherwise permitted by the Commissioner.

(i) The submission of a rider, application or endorsement shall specify the Policy or group of Policies with which it will be used. The identification code of such Policy or group of Policies shall be given together with, if possible, the approximate date of the original filing to expedite review. If a new form makes reference to the provisions of a form previously used that did not require filing or approval, it shall be accompanied by such previous form for reference purposes.

(j) Revisions shall not be made by rider, endorsement or amendment, except with prior approval of the Commissioner. No such riders, endorsements or amendments shall be submitted for approval unless the Issuer is notified in advance by the Commissioner that revision by rider, endorsement or amendment is permissible.

(k) All submitted material shall be filled in with appropriate hypothetical data.

(l) Applications to be attached to Policy forms upon issue must be attached to such forms upon submission. If such an application was previously filed and approved, the approximate date of such approval must be noted, if possible. Policy outlines of coverage prescribed in 211 CMR 71.13 must also be filed with the corresponding Policy forms, as well as application forms and notice regarding replacement of Medicare Supplement Insurance pursuant to 211 CMR 71.14.

(m) The cover letter must state whether the form is new or replaces an approved or previously filed form or forms.

(n) If a form replaces a previously approved or filed form, the identification code of the replaced form must be given and differences from the text of the replaced form must be noted.

Where an entire form has been rewritten to improve its readability, a general description of changes is sufficient. Substantive changes shall be carefully noted.

(o) If a form was previously disapproved, this fact must be set forth in the cover letter with the reasons why the form is resubmitted.

(p) Each submission must include a certification by a company official that each form meets the objective standards of M.G.L. c. 175, § 2B, as well as a certification by a company official that each form meets the minimum Flesch score requirements established by M.G.L. c. 175, § 2B. If an Issuer contends that a form is exempt from M.G.L. c. 175, § 2B, the basis for this contention must be stated in the cover letter.

(q) No Medicare Supplement Insurance Policy shall be offered, sold, delivered or issued for delivery, or otherwise made effective, or renewed in Massachusetts which provides benefits which duplicate benefits provided by Medicare. Except as otherwise approved by the Division, no such Policy shall provide lower benefits than are required by 211 CMR 71.00, *et seq*., except where duplication of Medicare benefits would otherwise result.

(r) As soon as practicable, but prior to the effective date of any changes in benefits provided by Medicare, Massachusetts laws regarding mandated health benefits and/or by the Medicare Supplement Insurance Policy, every Issuer shall file with the Division, in accordance with applicable filing procedures, any appropriate riders, endorsements or Policy forms needed to accomplish such Medicare Supplement Insurance modifications. Any such riders, endorsements or Policy forms shall provide a clear description of the Medicare Supplement benefits provided by the Policy.

(s) Within 90 days of the effective date of any changes in benefits provided by Medicare, Massachusetts laws regarding mandated health benefits and/or by the Medicare Supplement Insurance Policy, every Issuer shall have on file new Medicare Supplement Insurance policies that eliminate any duplication of benefits provided by Medicare. Each filing shall provide a clear description of the Policy benefits.

(t) Each submission must include a certification by an officer of the company that each form and outline of coverage filed complies with all applicable laws and regulations, including, but not limited to 211 CMR 71.00, *et seq*.

(10) Rate Manual. Every Issuer shall maintain on file with the Division an up-to-date rate manual for all Medicare Supplement Insurance Policies, riders, and endorsements currently available for sale in Massachusetts. Such manual shall be filed no later than 45 days after approval of new rates or Policy forms and shall include:

(a) name of the Issuer on each page;

(b) table of contents or index; and

(c) identification by form number of each Policy, rider or endorsement to which the rates apply.

(11) Rate Filings.

(a) Rate Filings for Medicare Supplement Insurance.

1. An Issuer shall submit a rate filing for any Medicare Supplement Insurance Policy described in 211 CMR 71.08(2) for which the Issuer seeks an initial rate or a change in rates, or any Medicare Supplement Insurance Policy issued to be effective prior to January 1, 1995 to a resident of Massachusetts for which the Issuer seeks a change in rates. All rate filings must comply with the provisions of 211 CMR 71.12(11).

2. Every Issuer desiring to increase or decrease premiums for any Medicare Supplement Insurance Policy, or desiring to set the initial premium for a new Medicare Supplement Insurance Policy described set forth in 211 CMR 71.08(2), shall, in accordance with applicable filing procedures, file with the Division a rate filing which complies with the provisions of 211 CMR 71.12(11).

3. For any Medicare Supplement Insurance Policy defined in 211 CMR 71.08(2), a rate filing shall be determined to have been filed only when it has been submitted in complete form in compliance with 211 CMR 71.12(11), and any accompanying Policy forms have been submitted in complete form in compliance with 211 CMR 71.12(9).

4. For any Medicare Supplement Insurance Policy originally issued to be effective prior to January 1, 1995, a rate filing shall be determined to have been filed only when it has been submitted in complete form in compliance with 211 CMR 71.12(11), and a copy of the Policy form and a statement of the date upon which that form had been approved have been submitted.

5. Every Issuer shall include in its filing all documents and information as are necessary to support the proposed rates, including where applicable, all documents required by 211 CMR 71.12(9) and (11) and applicable regulations specifying the procedures for rate hearings on such rate filings.

6. Any rate filing for Medicare Supplement Insurance Policies for which the proposed rate:

a. represents an increase in premium of less than 10% more than the premium previously charged by the Issuer for the same Policy; or

b. represents an initial premium request that is less than 10% more than the average premium for the same Policies charged by Issuers in the same class under 211 CMR 71.12(12);

shall be filed at least 30 days prior to the proposed effective date of such new rates.

7. Any rate filing for Medicare Supplement Insurance Policies for which the proposed rate:

a. represents an increase in premium of 10% or more than the premium previously charged by the Issuer for the same Policy;

b. represents an initial premium request that is 10% or more than the average premium for the same Policies charged by Issuers in the same class under 211 CMR 71.12(12); or

c. represents an initial premium for a new Medicare Supplement Insurance Policy to conform with the requirements of 211 CMR 71.00;

shall be filed at least 90 days prior to the proposed effective date of such new rates.

(b) Rate Filings for Evidences of Coverage Issued Pursuant to a Cost Contract.

1. A Health Maintenance Organization shall submit a rate filing for any Evidence of Coverage Issued Pursuant to a Cost Contract for which the HMO seeks a rate which represents an increase in premium of ten percent or more than the premium previously charged by the HMO for the same Evidence of Coverage Issued Pursuant to a Cost Contract; represents an initial premium request that is ten percent or more than the average premium for the same Evidences of Coverage charged by HMOs in the same class under 211 CMR 71.12(12); or represents an initial premium for a new Evidence of Coverage Issued Pursuant to a Cost Contract to conform with the requirements of 211 CMR 71.23(5). All rate filings must comply with the applicable provisions of 211 CMR 71.12(11).

2. A Health Maintenance Organization shall file a statement of any changes in premium rates for any Evidence of Coverage Issued Pursuant to a Cost Contract other than those specified in 211 CMR 71.12(11)(b)1. Such statement shall be filed with the Division no later than 30 days before the effective date of such proposed change in premium rates.

3. Every Health Maintenance Organization desiring to increase premiums or set the initial premium as described in 211 CMR 71.12(11)(b)1. for any Evidence of Coverage Issued Pursuant to a Cost Contract, shall, in accordance with applicable filing procedures, file with the Division a rate filing which complies with the provisions of 211 CMR 71.12(11).

4. For any Evidence of Coverage Issued Pursuant to a Cost Contract, a rate filing shall be determined to have been filed only when it has been submitted in complete form in compliance with 211 CMR 71.12(11), and the Evidence of Coverage Issued Pursuant to a Cost Contract forms to which the proposed rates apply have been submitted in complete form.

5. Every Health Maintenance Organization shall include in its filing all documents and information as are necessary to support the proposed rates, including where applicable, all documents and submissions required by 211 CMR 71.12(9)(a), (b), (d), (h), (k) and (t), 71.12(11) and applicable regulations specifying the procedures for rate hearings on such rate filings.

6. Any rate filing for Evidences of Coverage Issued Pursuant to a Cost Contract for which the proposed rate:

a. represents an increase in premium of 10% or more than the premium previously charged by the HMO for the same Evidence of Coverage Issued Pursuant to a Cost Contract;

b. represents an initial premium request that is ten percent or more than the average premium for the same Evidences of Coverage Issued Pursuant to a Cost Contract charged by HMOs in the same class under 211 CMR 71.12(12); or

c. represents an initial premium for a new Evidence of Coverage Issued Pursuant to a Cost Contract to conform with the requirements of 211 CMR 71.23(5).

shall be filed at least 90 days prior to the proposed effective date of such new rates and shall contain a copy of the relevant Evidence of Coverage Issued Pursuant to a Cost Contract.

(c) Three copies of a rate filing must be submitted with each submission of a Medicare Supplement Insurance Policy, rider, or endorsement that affects the premium rate to be charged, and with all changes in premium rates, whether made by endorsement to a Policy, by incorporating into a Policy by reference a table of rates on file with the Commissioner, or otherwise, unless otherwise provided by the Commissioner. Three copies of a rate filing must be submitted for rates for each Evidence of Coverage Issued Pursuant to a Cost Contract unless otherwise provided by the Commissioner. In the case of rate changes, filings shall note the extent of the changes. The Issuer or HMO shall also provide a copy of data included in the filing on a 3.5" floppy disk readable in IBM format, ASCII only, or other form specified by the Commissioner, unless otherwise provided by the Commissioner. Rate filings shall include properly identified rate manual pages, which may be in typed draft or other preliminary form. Policies and Evidences of Coverage Issued Pursuant to a Cost Contract submitted for rate approval by the Commissioner shall not state or imply that the Massachusetts Division of Insurance does not review the reasonableness of rate increases.

For rate filings subject to prior approval by the Commissioner, an Issuer or a Health Maintenance Organization shall provide all advertisements in, and notifications to, newspapers of the rate hearing required by 211 CMR 71.12(17)(b) for publication in a format and at a time specified by the Commissioner or as provided in applicable regulations specifying the procedures for rate hearings on such rate filings; and shall file evidence thereof with the Commissioner in a format and at a time specified by the Commissioner or as provided in applicable regulations specifying the procedures for rate hearings on such rate filings. The Issuer or Health Maintenance Organization shall obtain the date of the rate hearing and other information pertinent to the advertisement or notice from the Division.

(d) As soon as practicable, but prior to the effective date of any changes in benefits provided by Medicare and/or by the Medicare Supplement Insurance Policy or Evidence of Coverage Issued Pursuant to a Cost Contract, every Issuer providing Medicare Supplement Insurance in Massachusetts and every HMO offering an Evidence of Coverage Issued Pursuant to a Cost contract shall file with the Division, in accordance with applicable filing procedures,

appropriate premium adjustments necessary to produce loss ratios as originally anticipated for the applicable Policies or Evidences of Coverage Issued Pursuant to a Cost Contract. The supporting documents as are necessary to justify the adjustments shall accompany the filing.

(e) 1. Every Issuer providing a Medicare Supplement Insurance Policy form to a resident of Massachusetts and every HMO providing an Evidence of Coverage Issued Pursuant to a Cost Contract shall make premium adjustments necessary to produce an expected loss ratio under such Policy or Evidence of Coverage Issued Pursuant to a Cost Contract to conform to minimum loss ratio standards as prescribed by 211 CMR 71.12(12) where applicable and which is expected to result in a loss ratio at least as great as that originally anticipated by the Issuer for the Policies or Evidences of Coverage Issued Pursuant to a Cost Contract. No premium adjustments which would modify the loss ratio experience under the Policy or Evidence of Coverage Issued Pursuant to a Cost Contract other than the adjustments described herein shall be made with respect to a Policy or Evidence of Coverage Issued Pursuant to a Cost Contract at any time other than upon its renewal date, except as otherwise approved by the Division. Premium adjustments may be in the form of refunds or premium credits and shall be made no later than the lesser of 90 days after the date the premium adjustment is determined to be due, or upon renewal if a credit is given, or within the lesser of 90 days after the date the premium adjustment is determined to be due, or 60 days of the renewal date if a refund is provided to the premium payer. No Insured or Member may assign his or her rights to such premium adjustments to another person or entity.

2. If an Issuer or Health Maintenance Organization fails to make premium adjustments acceptable to the Commissioner, the Commissioner may order premium adjustments, refund or premium credits deemed necessary to achieve the loss ratio required by 211 CMR 71.12(12).

(f) Each rate filing shall be accompanied by an Actuarial Opinion and supporting actuarial memorandum prepared and certified by a qualified actuary, as defined in the instructions for the Life and Accident and Health Annual Statement Blank or Actuarial Standard of Practice No. 16, Actuarial Practice Concerning Health Maintenance Organizations and Other Managed-Care Health Plans, as appropriate. Such memorandum shall contain:

1. the formulas or methods used to obtain the gross premiums;

2. a list of all assumptions made in the rate calculations, including identification of mortality, morbidity, and lapse rate tables or experience studies used; as well as a list of all assumptions made in the calculation of any premium surcharge or discount to be charged to Insureds or Members, including the actuarial basis for the selection of the percentage surcharge or discount, and the identification of mortality, morbidity, lapse rate tables or experience used, and the extent to which the experience of Insureds or Members in different products was combined;

3. the pattern of the commission scale applicable to each form and a detailed list of all other anticipated expenses, including, but not limited to per claim expenses, taxes, underwriting and acquisition expenses, including where possible identification of those expenses which are fixed and those which are variable;

4. the expected claim or service costs;

5. the anticipated loss ratios for each of the first five years of coverage, year by year, and for the entire period (the lifetime) for which rates are computed to provide coverage in the Policy or Evidence of Coverage Issued Pursuant to a Cost Contract form. The anticipated loss ratio during the first five years shall be calculated on an earned-incurred rather than a written-paid basis. An anticipated loss ratio is defined as the present value at issue of the expected future benefits, excluding dividends, divided by the present value of the expected future annualized premiums from the first day the Policy or Evidence of Coverage Issued Pursuant to a Cost Contract form is sold to the last day that the form is in force. For a

given time period, a reasonable interest rate must be used. The aggregate anticipated loss ratios, based on reasonable assumptions as to the distribution of the Policy or Evidence of Coverage Issued Pursuant to a Cost Contract form shall also be calculated for each of the above time periods.

The calculations of the expected claims costs and the non-aggregated loss ratios shall be clearly described and illustrated.

(g) The following standards for maintaining experience data shall apply to support rate revisions.

1. Maintaining experience. Premium and loss data shall be recorded for each Policy or Evidence of Coverage Issued Pursuant to a Cost Contract form on the following basis for each calendar year: premiums written or paid; each reserve component; earned premiums; paid losses; and incurred losses.

2. Combining experience. Experience under different Policy or Evidence of Coverage Issued Pursuant to a Cost Contract forms where the premium and coverage are substantially the same must be combined.

3. Fund accounting. Experience data shall be maintained on the basis of fund accounts that will reflect premiums, investment income, losses, expenses, and provision for reserves.

(h) Each rate filing shall contain data supporting the expenses of the Issuer or Health Maintenance Organization in offering a Medicare Supplement Insurance Policy or an Evidence of Coverage Issued Pursuant to a Cost Contract, which are charged in the rates, including information concerning its utilization review programs and other techniques that have had or are expected to have a demonstrated impact on the prevention of reimbursement for services that are not medically necessary; provided, however, that Medicare Eligible Expenses which are determined medically necessary by Medicare shall be considered medically necessary by an Issuer or HMO.

(i) Each rate filing shall contain a legal opinion that the Issuer or Health Maintenance Organization is in compliance with the provisions of M.G.L. c. 176K and 211 CMR 71.00.

(j) Each rate filing for rates that represent an increase of 10% or more than the premium previously charged by the Issuer or Health Maintenance Organization, or for initial rates that are ten percent or more than the premium charged by the average of Issuers or HMOs in the same class under 211 CMR 71.12(12), or for initial rates for a new Medicare Supplement Insurance Policy issued to conform with 211 CMR 71.08(2) or for a new Evidence of Coverage Issued Pursuant to a Cost Contract, shall provide information that the Issuer or HMO employs a utilization review program and other techniques acceptable to the Commissioner which have had or are expected to have a demonstrated impact on the prevention of reimbursement by the Issuer or HMO for services which are not medically necessary; provided, however, that Medicare Eligible Expenses which are determined medically necessary by Medicare shall be considered medically necessary by an Issuer or HMO.

(k) Any requested rate increases for a Medicare Supplement Insurance Policy or Evidence of Coverage Issued Pursuant to a Cost Contract in excess of 10% from the premium previously charged by the Issuer or HMO shall be communicated by written notice to each Insured or Member so that the Insured or Member receives such notice at least ninety days prior to the effective date of such increase, unless otherwise provided by the Commissioner.

(12) Loss Ratio Standards.

(a) No Medicare Supplement Insurance Policy or Evidence of Coverage Issued Pursuant to a Cost Contract shall be issued, renewed, delivered, or issued for delivery unless the Policy or Evidence of Coverage Issued Pursuant to a Cost Contract form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to

policyholders or Members the form of aggregate benefits (not including anticipated refunds or credits) provided under the Policy or Evidence of Coverage Issued Pursuant to a Cost Contract form:

1. At least 95% of premium for Medicare Supplement Insurance issued by a non-profit hospital service corporation or medical service corporation for the 1994 Policy year;
2. At least 90% of premium for Medicare Supplement Insurance issued by a non-profit hospital service corporation or medical service corporation for subsequent Policy years;
3. At least 65% of premium earned from individual Medicare Supplement Insurance Policies issued by commercial Issuers, including, but not limited to Policies issued as a result of solicitations of individuals through the mails or through mass media advertising, including both print and broadcast advertising;
4. At least 75% of the aggregate amount of premiums earned in the case of group Policies, including, but not limited to Policies issued as a result of solicitations of individuals through the mails or by mass media advertising (including both print and broadcast advertising); or
5. At least 80% of premium earned from Evidences of Coverage Issued Pursuant to a Cost Contract issued by HMOs; calculated, with respect to Medicare Supplement Insurance Policies, on the basis of incurred claims experience and earned premiums for such period and in accordance with accepted actuarial principles and practices in a format prescribed or approved by the Commissioner; and calculated, with respect to Evidences of Coverage Issued Pursuant to a Cost Contract, on the basis of total incurred health care expenses for benefits supplemental to Medicare in accordance with accepted actuarial principles and practices in a format prescribed or approved by the Commissioner.

(b) Each type of Medicare Supplement Insurance described in 211 CMR 71.12(12)(a) offered by an Issuer and each type of Evidence of Coverage Issued Pursuant to a Cost Contract offered by an HMO shall independently meet the applicable minimum loss ratio standard.

(c) All filings of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with the requirements of 211 CMR 71.12 when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards.

(d) For Medicare Supplement Insurance Policies issued prior to July 30, 1992, expected claims in relation to premiums shall meet:

1. The originally filed anticipated loss ratio when combined with the actual experience since inception;
2. The appropriate loss ratio requirement from 211 CMR 71.12(12)(a)3. and 4. when combined with actual experience beginning with April 19, 1996 to date; and
3. The appropriate loss ratio requirement from 211 CMR 71.12(12)(a)3. and 4. over the entire future period for which the rates are computed to provide coverage.
4. In demonstrating compliance with the tests in 211 CMR 71.12(12)(d)1. through 3. and for the purposes of attaining credibility, the Issuer shall provide loss ratios based on combined experience under policy forms which provide substantially the same coverage, provided, however, that the experience of individual policies (including all group policies subject to an individual loss ratio standard when issued) may not be combined with any group policies.

(13) Refund or Credit Calculation.

(a) Each Issuer and each Health Maintenance Organization shall collect and file with the Commissioner by May 31 of each year, addressed to the Director of the State Rating Bureau, the data contained in the applicable reporting form prescribed by the Commissioner in 211 CMR 71.96: *Appendix D* for each type of Medicare Supplement benefit plan or Evidence

of Coverage Issued Pursuant to a Cost Contract, or in another format prescribed or approved by the Commissioner.

(b) If on the basis of the experience as reported the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), then a refund or credit calculation is required. The refund calculation shall be done on a statewide basis for each type of Medicare Supplement benefit plan or Evidence of Coverage Issued Pursuant to a Cost Contract. For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded.

(c) For the purposes of 211 CMR 71.12(13), for Medicare Supplement Insurance Policies or Certificates Issued prior to July 30, 1992, the Issuer shall make the refund or credit calculation separately for all individual policies (including all group policies subject to an individual loss ratio standard when issued) combined and all other group policies combined for experience after April 19, 1996. The first report shall be due by May 31, 1998.

(d) For the purposes of 211 CMR 71.12(13), beginning with reports for calendar year 2001, Non-Profit Hospital Service Corporations and Medical Service Corporations shall calculate the benchmark loss ratio that is part of the refund calculation using the applicable reporting form in 211 CMR 71.96(C)(2001-2016). All other Issuers shall calculate the benchmark loss ratio that is part of the refund calculation using the applicable reporting forms in 211 CMR 71.96(A) or (B).

(e) A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds a de minimis level. The refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the Secretary of Health and Human Services, but in no event shall it be less than the average rate of interest for 13-week Treasury notes. Premium adjustments may be in the form of refunds or premium credits and shall be made no later than the lesser of 90 days after the date the premium adjustment is determined to be due, or upon renewal if a credit is given, or within the lesser of 90 days after the date the premium adjustment is determined to be due, or 60 days of the renewal date if a refund is provided to the premium payer. No Insured or Member may assign his or her rights to such premium adjustments to another person or entity.

(f) The refund or credit calculation for Medicare Supplement Insurance made pursuant to 211 CMR 71.12(13) shall be based on actual monies received and spent. The refund or credit calculation for Evidences of Coverage Issued Pursuant to a Cost Contract shall be based on actual monies received and actual health care expenses incurred.

(g) A separate accounting of surcharges and discounts shall be filed with the Issuer's or HMO's annual loss ratio filing.

(14) Annual Filing of Premium Rates.

(a) An Issuer of Medicare Supplement Policies issued before or after January 1, 1995 and an HMO offering Evidences of Coverage Issued Pursuant to a Cost Contract issued before or after January 1, 1995 in Massachusetts shall file annually its rates, rating schedule and supporting documentation including ratios of incurred losses to earned premiums by Policy or Evidence of Coverage Issued Pursuant to a Cost Contract duration for approval by the Commissioner in accordance with the filing requirements and procedures prescribed by the Commissioner.

(b) The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. Such demonstration shall exclude active life reserves. An expected third-year loss ratio that is greater than or equal to the applicable percentage shall be demonstrated for Policies or Evidences of Coverage Issued Pursuant to a Cost Contract in force less than three years.

(c) The filing shall also include data on the number of new Medicare Supplement Insurance Policies and Evidences of Coverage Issued Pursuant to a Cost Contract sold and Policies and Evidences of Coverage Issued Pursuant to a Cost Contract lapsed in the previous year, and the total number of Policies and Evidences of Coverage Issued Pursuant to a Cost Contract in force as of December 31 of the previous year.

(d) Every Issuer and Health Maintenance Organization that issues Medicare Supplement Insurance Policies or Evidences of Coverage Issued Pursuant to a Risk or Cost Contract subject to 211 CMR 71.00 shall file annually with the Commissioner an Actuarial Opinion and a legal opinion that certifies that the Issuer's or HMO's rating methodologies and rates comply with the requirements of M.G.L. c. 176K and 211 CMR 71.00, *et seq*., and shall maintain at its principal place of business (or, if such principal place of business is not in Massachusetts, at a location within the City of Boston) a complete and detailed description of its rating practices for inspection by the Commissioner or his or her designee.

(15) Standards for Disapproval of Rates. Rate filings may be disapproved by the Commissioner if the benefits provided therein are unreasonable in relation to the rate charged, or if the rates are excessive, inadequate or unfairly discriminatory or do not otherwise comply with the requirements of M.G.L. c. 176K or 211 CMR 71.12. Notwithstanding the foregoing, where applicable, rate filings made under 211 CMR 71.12 are also subject to the provisions of applicable regulations specifying the procedures for rate hearings on such rate filings.

(16) Time Provisions for Medicare Supplement Insurance Rate Filings Required to be Filed at least 30 Days Before a Proposed Effective Date. For all Medicare Supplement Insurance rate filings required to be filed at least 30 days before a proposed rate effective date pursuant to 211 CMR 71.12(11)(a)6., the following time provisions shall apply:

(a) If not disapproved by the Commissioner, such filing shall be deemed to be approved by the Commissioner 30 days after filing unless a hearing has commenced within 30 days of the filing and a decision thereon is pending.

(b) Such filing shall not be disapproved by the Commissioner except after a hearing conducted pursuant to M.G.L. c. 30A and applicable regulations specifying the procedures for rate hearings on such rate filings within 30 days after such filing.

(c) Filings resubmitted to conform to the terms of a decision disapproving proposed rates shall be reviewed as part of the same hearing as that in which the Division considered the original filings. All other filings resubmitted thereafter shall be considered to be new filings for the purposes of 211 CMR 71.00, *et seq*.

(d) Any initial premium rate increase and any other increase in premium rates shall continue in effect for not less than 12 months, except that an increase in benefits or a decrease in rates may be permitted at any time.

(17) Time Provisions for Rate Filings Required to be Filed at least 90 Days before a Proposed Rate Effective Date. For all rate filings for Medicare Supplement Insurance and Evidences of Coverage Issued Pursuant to a Cost Contract required to be filed at least 90 days before a proposed rate effective date pursuant to 211 CMR 71.12(11)(a)7. and (11)(b)6., the following time provisions shall apply:

(a) The Issuer or Health Maintenance Organization shall file the rate request no later than 90 days prior to the requested effective date.

(b) The Division shall hold a public hearing pursuant to applicable regulations specifying the procedures for rate hearings on such rate filings within 30 days after the filing is made. Notice of the public hearing will be given to, or advertised in, newspapers in Boston, Brockton, Fall River, Pittsfield, Springfield, Worcester, New Bedford, and Lowell as provided in 211 CMR 71.12(11)(c).

(c) The Commissioner shall approve or disapprove the requested rates within 30 days following the conclusion of the public hearing. If the filing is disapproved and a revised filing conforming to the terms of the decision is resubmitted in accordance with applicable regulations specifying the procedures for rate hearings on such rate filings, it shall be approved. Filings resubmitted thereafter shall be considered to be new filings for the purposes of 211 CMR 71.00 and applicable regulations specifying the procedures for rate hearings on such rate filings.

(d) Any increase in premium rates shall continue in effect for not less than 12 months, except that an increase in benefits or a decrease in rates may be permitted at any time.

(e) Notice shall be given to all Insureds or Members of such requested increase in premium rates no less than 90 days before the proposed rate effective date, unless otherwise provided by the Commissioner pursuant to 211 CMR 71.12(11)(k).

(18) Appeals. The submission and approval of a revised rate filing by an Issuer or a Health Maintenance Organization shall not affect the Issuer s or HMO's right to appeal from those elements of the requested rate filing that were disapproved. Any order, decree, or judgment of the Supreme Judicial Court modifying, amending, annulling, or reversing a decision of the Commissioner disapproving a rate filing, and any further decision of the Commissioner pursuant to such an order, decree, or judgment that affects the overall rate approved shall be effective as of the effective date permitted by the order from which the appeal was taken.

(19) Public Hearings. The Commissioner may conduct a public hearing to gather information concerning a request by an Issuer or a Health Maintenance Organization for an increase in a rate for a Policy or Evidence of Coverage Issued Pursuant to a Cost Contract form issued before or after January 1, 1995, if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance is made without consideration of any refund or credit for such reporting period. Public notice of the hearing shall be furnished in accordance with applicable statutory requirements.

71.13: Required Disclosure Provisions

(1) General Rules.

(a) Each Medicare Supplement Insurance Policy covered by 211 CMR 71.00 shall have an outline of coverage. The outline of coverage is prescribed in 211 CMR 71.13(2). This outline of coverage shall not be part of a Policy.

(b) Issuers shall provide an outline of coverage to all Applicants at the time the application is presented to the prospective Applicant and, except for direct response policies, shall obtain an acknowledgment of receipt of the outline of coverage from the Applicant.

(c) If the Policy issued is different from the Policy for which an application was made and for which an outline of coverage was previously issued, a revised outline of coverage, properly describing the Policy, shall be attached to the Policy. Such revised outline of coverage shall contain the following statement in no less than 12-point type, immediately above the company name:

"NOTICE: Read this outline of coverage summary carefully. It is not identical to the summary provided upon application and the coverage originally applied for has not been issued."

(d) Except for riders or endorsements by which the Issuer effectuates a request made in writing by the Insured, exercises a specifically reserved right under a Medicare Supplement Policy, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits, all riders or endorsements added to a Medicare Supplement Policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the Policy shall

require a signed acceptance by the Insured. After the date of Policy or Certificate issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the Policy term shall be agreed to in writing signed by the Insured, unless the benefits are required by the minimum standards for Medicare Supplement policies, or if the increased benefits or coverage is required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the Policy.

(e) Each Policy shall have a notice prominently printed on the first page of the Policy or Certificate or attached thereto stating in substance that the policyholder or certificateholder shall have the right to return the Policy or Certificate within 30 days of its delivery and to have the premium refunded if, after examination of the Policy or Certificate, the insured person is not satisfied for any reason.

(f) Each Policy shall not provide for the payment of benefits based on standards described as usual and customary," "reasonable and customary," or words of similar import.

(g) Each Policy shall have a specification page and shall provide the following information:

1. The Policy number;
2. The name of the Insured;
3. The effective date, assuming the premium for the Policy has been paid on or before that date;
4. A listing of the premium or premiums payable and the periods to which they apply.

(h) No misleading Policy names shall be used. A carrier's Policy name shall not misrepresent the extent of benefits actually provided. Carriers shall not use the name "Medicare Supplement," "Medigap" or similar terms except to describe a Policy that complies with 211 CMR 71.00.

(i) All outlines of coverage for Medicare Supplement Insurance must be filed with the Division of Insurance pursuant to 211 CMR 71.12(9)(l).

(2) Disclosure Standards.

(a) Applicants and Insureds are to be clearly informed of the basic nature and provisions of Medicare Supplement Insurance policies through an outline of coverage for each Policy which summarizes its contents. The outline of coverage shall simply and accurately describe benefits provided by Medicare. The outline of coverage shall also accurately describe the Medicare Supplement Insurance Policy benefits along with benefit limitations.

(b) The outline of coverage consists of three parts: a cover page (211 CMR 71.13(2)(c)1. and 211 CMR 71.98: *Appendix F*; text of outline of coverage including premium information, disclosures and Massachusetts Summary (211 CMR 71.13(2)(c)2.; and charts (211 CMR 71.13(2)(c)3. and 211 CMR 71.99: *Appendix G*. The premium information, disclosures and Massachusetts Summary portions of the outline of coverage shall be in the language and format prescribed below in no less than 12-point type. All plans prescribed by 211 CMR 71.90, 71.91 and 71.92 shall be shown on the cover page, and the plan(s) that are offered by the insurer shall be prominently identified. Premium information for plans that are offered shall be shown on the cover page and shall be prominently displayed. The premium and mode shall be stated for all plans that are offered to the prospective Applicant. All possible premiums for the prospective Applicant shall be illustrated. The outline of coverage including the precise format and language to be used, is set out below in 211 CMR 71.13(2)(c).

(c) Outline of Coverage. The following items shall be included in the outline of coverage in the order prescribed below:

1. Cover Page. [The cover page shall be in the precise format and language set out in 211 CMR 71.98: *Appendix G*]
2. Text of Outline of Coverage:

ASSACHUSETTS MEDICARE SUPPLEMENT INSURANCE OUTLINE OF COVERAGE
(ISSUER'S NAME)
(Issuer's Policy Name and Number)
Policy Category: MEDICARE SUPPLEMENT INSURANCE
"NOTICE TO BUYER: This Policy may not cover all of the costs associated with medical care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all Policy limitations."

PREMIUM INFORMATION [Boldface Type]

We [insert Issuer' s name] can only raise your premium if we raise the premium for all policies like yours in Massachusetts, and if approved by the Commissioner of Insurance. If you choose to pay your premium on a quarterly, semiannual, or annual basis, upon your death, we will refund the unearned portion of the premium paid. If you choose to pay your premium on a quarterly, semiannual, or annual basis and you cancel your policy, we [insert either will or will not] refund the unearned portion of the premium paid. In the case of death [insert if the unearned portion of the premium will be refunded if coverage is canceled: or your cancellation of the policy] the unearned portion of the premium will be refunded [insert on a pro-rata basis or insert methodology which has been submitted to and approved by the Commissioner].

DISCLOSURES [Boldface Type]

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY [Boldface Type]

This is only an outline describing your Policy's most important features. The Policy is your insurance contract. You must read the Policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY [Boldface Type]

If you find that you are not satisfied with your Policy, you may return it to [insert Issuer's address]. If you send the Policy back to us within 30 days after you receive it, we will treat the Policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT [Boldface Type]

If you are replacing another health insurance Policy, do NOT cancel it until you have actually received your new Policy and are sure you want to keep it. If you cancel your present Policy and then decide that you do not want to keep your new Policy, it may not be possible to get back the coverage of the present Policy.

NOTICE [Boldface Type]

This Policy may not fully cover all of your medical costs.

[for agents:]
Neither [insert company's name] nor its agents are connected with Medicare.

[for direct response:]
[insert company' s name] is not connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult "Medicare & You" for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT [Boldface Type]

When you fill out the application for the new Policy, be sure to answer truthfully and completely all questions. The company may cancel your Policy and refuse to pay any claims if you leave out or falsify important information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

[The term "Certificate" should be substituted for the word "Policy" throughout the outline of coverage where appropriate.]

[The Medicare Supplement outline of coverage shall include the following statement, entitled Massachusetts Summary. The provision concerning "Complaints" must be set forth in a separate paragraph.]

MASSACHUSETTS SUMMARY [Boldface Type]

The Commissioner of Insurance has set standards for the sale of Medicare Supplement Insurance Policies. Such policies help you pay hospital and doctor bills, and some other bills, that are not covered in full by Medicare. Please note that the benefits provided by Medicare and this Medicare Supplement Insurance Policy may not cover all of the costs associated with your treatment. It is important that you become familiar with the benefits provided by Medicare and your Medicare Supplement Insurance Policy. This Policy summary outlines the different coverages you have if, in addition to this Policy, you are also covered by Part A (hospital bills, mainly) and Part B (doctors' bills, mainly) of Medicare.

Under M.G.L. c. 112, § 2, no physician who agrees to treat a Medicare beneficiary may charge to or collect from that beneficiary any amount in excess of the reasonable charge for that service as determined by the United States Secretary of Health and Human Services. This prohibition is commonly referred to as the ban on balance billing. A physician is allowed to charge you or collect from your insurer a copayment or coinsurance for Medicare-covered services. However, if your physician charges you or attempts to collect from you an amount which together with your copayment or coinsurance is greater than the Medicare-approved amount, please contact the Board of Registration in Medicine at [insert the telephone number for the Massachusetts Board of Registration in Medicine regarding licensing].

We cannot explain everything here. Massachusetts law requires that personal insurance policies be written in easy-to-read language. So, if you have questions about your coverage not answered here, read your Policy. If you still have questions, ask your agent or company. You may also wish to get a copy of "Medicare & You", a small book put out by Medicare that describes Medicare benefits.

THE BENEFITS TO PREMIUM RATIO FOR EACH POLICY SOLD is ___%.

[Insert here the lifetime aggregate anticipated loss ratio from 211 CMR 71.12(10)(a). If the ratio is different for different Policy forms, then separately specify the ratio for each Policy form. Heading should be in Boldface type.]

This means that during the anticipated life of your Policy and others just like it, the company expects to pay out $___ in claims made by you and all other policyholders for every $100 it collects in premiums. The minimum ratio allowed for policies of this type is ___%. A higher ratio is to your advantage as long as it allows the company a reasonable return so that the product remains available.

[If the ratio is different for different Policy forms, then provide a separate paragraph for each Policy form.]

COMPLAINTS [Boldface type]

If you have a complaint, call us at [area code and telephone number] or your agent. If you are not satisfied, you may write or call the Massachusetts Division of Insurance, [insert the address of the Massachusetts Division of Insurance]or call [insert the telephone number of the consumer helpline at the Massachusetts Division of Insurance].

3. Charts

[Insert here a comparison of the benefits available under Medicare A and B, and the three Medicare Supplement Insurance policies in the form prescribed in 211 CMR 71.99: *Appendix G*.]

(d) Notice Requirements.

1. Notice of Changes. As soon as practicable, but no later than 30 days prior to the annual effective date of any Medicare benefit changes, every Issuer providing Medicare Supplement Insurance or benefits to a resident of Massachusetts shall notify its Insureds of modifications it has made to its Medicare Supplement Insurance policies as a result of any changes to the Medicare program or to 211 CMR 71.00. The notice shall be in a format prescribed by the Commissioner. The notice shall:

   a. Include a separate description of revisions to the Medicare program, if any, and a description of each modification made to the coverage provided under the Medicare Supplement Policy, as well as how those changes affect the premium, if at all. If there is no change in the premium, the notice must explain why not.

   b. Inform each Insured as to when a premium adjustment, if any, will be made due to changes in Medicare benefits or the Medicare Supplement Policy.

   c. Be in outline form and in clear and simple terms so as to be easy to read.

   d. Be clearly labeled and shall not contain or be accompanied in the same mailing by any solicitation or other notices.

2. Revised Policy Form. No later than 90 days after the date of approval of Medicare Supplement Insurance rates, every Issuer providing Medicare Supplement Insurance, upon satisfying the filing and approval requirements of 211 CMR 71.00, *et seq*. and applicable regulations specifying the procedures for rate hearings on such rate filings, shall provide each Insured with any rider, endorsement or revised Policy form necessary to eliminate any benefit duplication under the Policy with benefits provided by Medicare. Such revision shall not be made by rider or endorsement unless approved by the Commissioner.

3. Revised Policy Outline of Coverage. No later than 90 days after the date of approval of Medicare Supplement Insurance rates and in addition to the notice of changes prescribed by 211 CMR 71.13(2)(d)1., every Insured covered by a Medicare Supplement Insurance Policy shall be provided with a revised outline of coverage which reflects any changes made to the Medicare program or to their Medicare Supplement Insurance Policy.

Such outline of coverage shall comply with the provisions of 211 CMR 71.13(2)(a), (b) and (c).

4. Guide to Health Insurance for People with Medicare.

a. Issuers of accident and sickness policies or Certificates which provide hospital or medical expense coverage on an expense incurred or indemnity basis to a person(s) eligible for Medicare shall provide to those Applicants a *Guide to Health Insurance for People with Medicare* in the form developed jointly by the National Association of Insurance Commissioners and the Health Care Financing Administration and in a type size no smaller than 12 point type. The *Guide* shall also include an attachment concerning the Massachusetts Medicare Supplement Insurance Program in a form prescribed by the Commissioner in a type size no smaller than 12-point type. Delivery of the *Guide* shall be made whether or not such policies or Certificates are advertised, solicited or issued as Medicare Supplement policies or Certificates as defined in 211 CMR 71.00. Except in the case of direct response carriers, delivery of the *Guide* shall be made to the Applicant at the time of application and acknowledgment of receipt of the *Guide* shall be obtained by the insurer. Direct response carriers shall deliver the *Guide* to the Applicant upon request but not later than at the time the Policy is delivered.

b. For the purposes of 211 CMR 71.13(2)(d)4.a., "form" means the language, format, type size, type proportional spacing, bold character and line spacing.

5. Required Notice for Non-Medicare Supplement Policies.

a. Any accident and sickness insurance or long-term care insurance Policy or Certificate, other than a Medicare Supplement Policy, a Policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. § 1395, *et seq*.); disability income Policy or other Policy identified in 211 CMR 71.02(2), issued for delivery in Massachusetts to persons eligible for Medicare shall notify Insureds under the Policy that the Policy is not a Medicare Supplement Policy or Certificate. The notice shall either be printed or attached to the first page of the outline of coverage delivered to Insureds under the Policy, or if no outline of coverage is delivered, to the first page of the Policy, or Certificate delivered to Insureds. The notice shall be in no less than 12 point type and shall contain the following language:

> "THIS [POLICY OR CERTIFICATE] IS NOT A MEDICARE SUPPLEMENT [POLICY OR CONTRACT]. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company. "

b. Applications provided to persons eligible for Medicare for the health insurance or long-term care insurance policies or certificates described in 211 CMR 71.13(2)(d)(5.)(a.) shall disclose, using the applicable statement in 211 CMR 71.100 - *Appendix H*, the extent to which the policy duplicates Medicare. The disclosure statement shall be provided as a part of, or together with, the application for the policy or certificate.

71.14: Requirements for Application or Replacement

(1) Application forms shall include the following questions and statements in precisely the following form designed to elicit information as to whether, as of the date of the application, the Applicant has another Medicare Supplement or other health insurance Policy or Certificate in force or whether a Medicare Supplement Policy or Certificate is intended to replace any other accident and sickness Policy or Certificate presently in force. A supplementary application or

other form to be signed by the Applicant and agent containing such questions and statements may be used.

[Statements]

(a) You do not need more than one Medicare Supplement Policy.
(b) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
(c) You may be eligible for Medicaid benefits and may not need a Medicare Supplement Policy.
(d) The benefits and premiums under your Medicare Supplement Policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your Policy will be reinstituted if requested within 90 days of losing Medicaid eligibility.
[Issuers that permit a period of suspension for longer than 24 months should delete "for 24 months" and insert the appropriate limitation.]
(e) Counseling services are available in Massachusetts to provide advice concerning your purchase of Medicare Supplement Insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB). You may call the Massachusetts Executive Office of Elder Affairs insurance counseling program at [insert the toll-free number of the Massachusetts Executive Office of Elder Affairs] or write to that office at the following address for more information: [insert the address of the Massachusetts Executive Office of Elder Affairs]

[Questions]

To the best of your knowledge,
(a) Do you have another Medicare Supplement Policy or Certificate in force?
1. If so, with which company?
2. If so, do you intend to replace your current Medicare supplement policy with this policy [certificate]?

(b) Do you have any other health insurance coverage that provides benefits similar to this Medicare Supplement Policy?
1. If so, with which company?
2. What kind of Policy?

(c) Are you covered for medical assistance through the Massachusetts Medicaid program:
1. As a Specified-Low Income Medicare Beneficiary (SLMB)?
2. As a Qualified Medicare Beneficiary (QMB)?
3. For other Medicaid medical benefits?

(2) Agents shall list any other health insurance policies they have sold to the Applicant.
(a) List policies sold which are still in force.
(b) List policies sold in the past five years which are no longer in force.

(3) In the case of a direct response Issuer, a copy of the application or supplemental form, signed by the Applicant, and acknowledged by the Issuer, shall be returned to the Applicant by the Issuer upon delivery of the Policy.

(4) Upon determining that a sale will involve replacement of Medicare Supplement coverage, any Issuer, other than a direct response Issuer, or its agent, shall furnish the Applicant, prior to issuance or delivery of the Medicare Supplement Policy or Certificate, a notice regarding replacement of Medicare Supplement coverage. One copy of the notice signed by the Applicant and the agent, except where the coverage is sold without an agent, shall be provided to the Applicant and an additional signed a copy shall be retained by the Issuer. A direct response Issuer shall deliver to the Applicant at the time of the issuance of the Policy the notice regarding replacement of Medicare Supplement coverage.

(5) The notice required by 211 CMR 71.14(4) for an Issuer shall be provided in precisely the following form in no less than 12-point type:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF
MEDICARE SUPPLEMENT INSURANCE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to terminate existing Medicare Supplement Insurance and replace it with a Policy to be issued by [Company Name] Insurance Company. Your new Policy will provide 30 days within which you may decide without cost whether you desire to keep the Policy. You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare Supplement coverage is a wise decision, you should terminate your present Medicare supplement coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, AGENT, BROKER OR
OTHER REPRESENTATIVE:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement coverage because you intend to terminate your existing Medicare supplement coverage. The replacement Policy is being purchased for the following reason(s) (check one):

_____ Additional benefits
_____ No change in benefits, but lower premiums.
_____ Fewer benefits and lower premiums.
_____ Other. (please specify)

_____

_____

__

(1) State law provides that your replacement Policy or Certificate may not contain any preexisting conditions, waiting periods, elimination periods or probationary periods.

(2) If you still wish to terminate your present Policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application. Failure to include all material information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your Policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present Policy until you have received your new Policy and are sure that you want to keep it. If you cancel your present Policy and then decide that you do not want to keep your new Policy, it may not be possible to get back the coverage of the present Policy.

_____
(Signature of Agent, Broker or Other Representative)*

[Typed Name and Address of Issuer, Agent or Broker]

_____
(Applicant's signature)

_____
(Date)

[*Signature not required for direct response sales.]

71.15: Appropriateness of Recommended Purchase and Excessive Insurance

(1) In recommending the purchase of any Medicare Supplement Insurance Policy or Certificate a producer and/or Issuer shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

(2) Any sale of Medicare Supplement coverage that will provide an individual more than one Medicare Supplement Policy or Certificate is prohibited.

71.16: Standards for Marketing

(1) Every Issuer or other entity marketing Medicare Supplement Insurance in Massachusetts directly or through its producers, shall establish marketing procedures:

(a) to ensure that any comparison of policies by its agents or other producers will be fair and accurate.

(b) to ensure excessive insurance is not sold or issued.

(c) to ensure that Insureds are informed that the Policy they are purchasing does not cover all of the costs associated with medical care incurred by the Insureds by displaying prominently by type, stamp or other appropriate means, on the first page of the Policy the following:
"Notice to Buyer: This Policy may not cover all of your medical expenses."

(d) to inquire and otherwise make every reasonable effort to identify whether a prospective Applicant or enrollee for Medicare Supplement Insurance already has accident and sickness insurance and the types and amounts of any such insurance.

(e) to ensure that Applicants and Insureds are clearly informed of the basic nature and provisions of their Medicare Supplement Insurance Policy.

(f) to ensure that Insureds are clearly informed as to the benefits provided by Medicare.

(2) Every Issuer or entity marketing Medicare Supplement Insurance in Massachusetts, directly or through its producers, is prohibited from "cold lead advertising," " twisting" or "high pressure tactics," as defined in 211 CMR 71.03.

(3) Every Issuer or other entity marketing Medicare Supplement Insurance in Massachusetts, directly or through its producers, shall establish auditable procedures for verifying compliance with 211 CMR 71.16.

(4) The terms "Medicare Supplement," "Medigap" and words of similar import shall not be used to describe a Medicare Supplement Policy unless such Policy is issued in compliance with 211 CMR 71.00.

71.17: Filing Requirements for Advertising

As soon as possible, but no later than 15 days before an Advertisement is used, every Issuer providing Medicare Supplement Insurance in Massachusetts shall file with the Commissioner for review, addressed to the Director of the State Rating Bureau, two copies of any Advertisement, whether through written, radio or television medium, intended for use in Massachusetts. Such Advertisements shall comply with all applicable laws.

71.18: Permitted Agent Compensation Arrangements

(1) An Issuer or other entity may provide commissions or other compensation to a producer for the sale of a Medicare Supplement Policy only if the first year commission or other first year compensation is no more than 200% of the commission or other compensation paid for selling or servicing the Policy in the second year or period.

(2) The commission or other compensation provided in subsequent (renewal) years must be the same as that provided in the second year or period and must be provided for no fewer than five renewal years.

(3) No entity shall provide compensation to its producers and no producer shall receive compensation greater than the renewal compensation payable by the replacing Issuer on renewal policies if an existing Policy is replaced.

71.19: Reporting of Multiple Policies

(1) On or before March 1 of each year, an Issuer shall report the following information for every individual resident of Massachusetts for which the Issuer has in force more than one Medicare Supplement Policy or Certificate:

(a) Policy and Certificate number; and

(b) date of issuance.

(2) The items set forth above must be grouped by individual policyholder.

(3) The information required by 211 CMR 71.19 shall be reported on a form prescribed by the Commissioner in 211 CMR 71.97: *Appendix E* and addressed to the Director of the State Rating Bureau at the Division of Insurance.

71.20: Permitted Surcharges or Discounts for Medicare Supplement Insurance and Evidences of Coverage Issued Pursuant to Cost Contracts

(1) To the extent permitted by federal law and subject to the provisions of 211 CMR 71.10(5), as of January 1, 1995, an Issuer or a Health Maintenance Organization may apply a surcharge to the premium for a Medicare Supplement Insurance Policy or an Evidence of Coverage Issued Pursuant to a Cost Contract for an Eligible Person who is a Late Enrollee or who Upgrades Coverage. For Late Enrollees, a surcharge may be applied unless the Reasonably Actuarially

Equivalent prior coverage was continuous from either the Late Enrollee's initial eligibility or three years prior to the effective date of the new coverage, whichever is later. Any surcharge may not exceed 15% annually and may not be charged for more than three years from the date it is imposed by the carrier. Each annual surcharge shall be applied to the premium for that year. No surcharge may be imposed by an Issuer or an HMO unless that Issuer or HMO also applies discounts for the Medicare Supplement Insurance Policy or Evidence of Coverage Issued Pursuant to a Cost Contract in accordance with 211 CMR 71.20(2).

(2) To the extent permitted by federal law, as of January 1, 1995, an Issuer or a Health Maintenance Organization may discount the premium for such Medicare Supplement Insurance Policy or Evidence of Coverage Issued Pursuant to a Cost Contract for a person who has enrolled during the six month period beginning at the time the person become initially eligible for coverage after attaining age 65. Any discount may not exceed 15% annually and may not be applied for more than three years from the date the Eligible Person first receives coverage. Each annual discount shall be applied against the premium for that year.

(3) To the extent permitted by federal law, an Issuer or a Health Maintenance Organization which desires to apply a surcharge or discount to the premium for a Medicare Supplement Insurance Policy or Evidence of Coverage Issued Pursuant to a Cost Contract shall support its proposed surcharge or discount in its Rate Filing as provided in 211 CMR 71.12(11)(f).

(4) To the extent permitted by federal law, an Issuer or a Health Maintenance Organization which applies a surcharge or discount to the premium for a Medicare Supplement Insurance Policy or Evidence of Coverage Issued Pursuant to a Cost Contract shall comply with the refund and credit calculation requirements of 211 CMR 71.12(13).

(211 CMR 71.21: Reserved for Medicare Select)

71.22: Withdrawal From the Market for Medicare Supplement Insurance

(1) An Issuer that participates in the market for Medicare Supplement Insurance on or after January 1, 1995 may not withdraw from the market until all the Insureds of the Issuer have had an opportunity to obtain coverage as of the next June 1 under a Medicare Supplement Insurance Policy offered by another Issuer or Evidence of Coverage Issued Pursuant to a Risk or Cost Contract offered by a Health Maintenance Organization during the annual open enrollment period outlined in 211 CMR 71.10(5), or the open enrollment periods outlined in 211 CMR 71.10(3) and (4) if such open enrollment periods allow all of the Issuer's Insureds to obtain coverage prior to the next June 1.

(2) An Issuer that withdraws from the market for Medicare Supplement Insurance pursuant to 211 CMR 71.22(1), shall provide to the Commissioner of Insurance a notice of withdrawal and withdrawal plan at least 60 days prior to February 1 of any calendar year which is the start of the annual open enrollment period pursuant to 211 CMR 71.10(5). Such withdrawal plan shall describe in detail how the Issuer intends to comply with 211 CMR 71.22(1) and shall be subject to the Commissioner's approval. In addition, the Issuer shall be required to provide written notice to all of its Insureds of the approved withdrawal plan.

(3) An Issuer that withdraws from the market for Medicare Supplement Insurance on or after January 1, 1995 may not Participate in the Market for Medicare Supplement Insurance in Massachusetts for five years from the date of withdrawal, unless the Commissioner finds that such re-entry shall be permitted earlier than five years due to a compelling interest.

(4) For the purposes of 211 CMR 71.22(1) through (3), "Withdraw or Withdraws from the Market" shall mean that the Issuer has discontinued the availability of all of its Policy forms and Certificate forms pursuant to 211 CMR 71.12(6).

(5) For the purposes of 211 CMR 71.22(2) and (3), the "Date of Withdrawal" shall mean the date which the Issuer discontinued the availability of all of its Policy forms and Certificate forms pursuant to 211 CMR 71.22(1).

71.23: Health Maintenance Organizations and Evidences of Coverage Issued Pursuant to a Risk or Cost Contract

(1) Any Health Maintenance Organization that issues an Evidence of Coverage Issued Pursuant to a Risk or Cost Contract shall meet the requirements of M.G.L. c. 176G and 211 CMR 43.00 and all other applicable Massachusetts laws and regulations.

(2) Any Health Maintenance Organization that Participates in the Market for Evidences of Coverage Issued Pursuant to a Risk or Cost Contract shall comply with the applicable requirements of 211 CMR 71.10.

(3) Any Evidence of Coverage Issued Pursuant to a Cost Contract issued or renewed to be effective on or after January 1, 1995 shall comply with the applicable requirements of 211 CMR 71.12.

(4) To the extent permitted by federal law, any Health Maintenance Organization which chooses to apply surcharges and discounts to rates charged for Evidences of Coverage Issued Pursuant to a Cost Contract shall do so in compliance with the requirements in 211 CMR 71.20.

(5) Outpatient Prescription Drug Benefits.

(a) A Health Maintenance Organization which Participates in the Market for Evidences of Coverage Issued Pursuant to a Risk or Cost Contract must offer an Evidence of Coverage which contains the required minimum outpatient prescription drug benefit defined in 211 CMR 71.23(5)(b), and may offer, in addition, Evidence of Coverages which contain no outpatient prescription drug benefit.

(b) Required Minimum Outpatient Prescription Drug Benefit. Any Evidence of Coverage Issued Pursuant to a Risk or Cost Contract which is issued to be effective on or after January 1, 1995 shall meet the requirements contained in M.G.L. c. 176G and 211 CMR 43.00, as well as other applicable Massachusetts laws and statutes; provided, however, that in addition to such requirements, any Health Maintenance Organization which issues any Evidences of Coverage Issued Pursuant to a Risk or Cost Contract(s) to be effective on or after January 1, 1995 shall make available to each prospective member an Evidence of Coverage containing either of the following benefits for Outpatient Prescription Drugs and shall not make available any Evidence of Coverage containing lower benefits for Outpatient Prescription Drugs:

1. a copayment amount to be no higher than $8 for each generic prescription or refill and a copayment amount to be no higher than $15 for each brand name prescription or refill; or
2. a copayment amount to be no higher than $10 for each generic or brand name prescription or refill.

provided, however, that each such prescription or refill shall contain the lesser of the clinically appropriate supply for a spell of illness or a 90 days' supply.

(c) Optional Mail Service Drug Benefit. In addition to the benefit required by 211 CMR 71.23(5)(a), a Health Maintenance Organization may provide coverage for a mail service prescription drug program for Outpatient Prescription Drugs for which federal law requires a prescription in the same Evidence of Coverage Issued Pursuant to a Risk or Cost Contract. The benefit must be approved by the Commissioner in advance; provided, however that the Member shall only be charged a copayment and the Member's copayments for Outpatient Prescription Drugs shall be either 1) no higher than $8 for each generic prescription or refill and no higher than $15 for each brand name prescription or refill; or 2) no higher than $10 for each generic or brand name prescription or refill; and provided, further, that each such prescription or refill shall contain a minimum of 21 days' and a maximum of 90 days' supply.

(d) A Health Maintenance Organization may not issue an Evidence of Coverage Issued Pursuant to a Risk or Cost Contract to be effective on or after January 1, 1995 which limits the total benefit that a Member may receive for Outpatient Prescription Drugs, which has copayment amounts that are higher than that allowed in 211 CMR 71.23(5)(a) or (b), or which has a deductible amount.

(e) For the purposes of 211 CMR 71.23(5), "Outpatient Prescription Drugs" includes insulin, as well as the needles, syringes, pumps and pump supplies necessary for the administration of insulin and blood sugar level testing equipment and supplies for use at home; drugs provided by a home infusion therapy provider; and drugs used on an off-label bases for the treatment of cancer or HIV/AIDS and medically necessary services associated with the administration of such drugs as required by M.G.L. c. 176G, § 4E, as amended from time to time, or by M.G.L. c. 176G, § 4G, as amended from time to time, and drugs and devices for hormone replacement therapy for peri and post menopausal women and for outpatient prescription contraceptive drugs or devices as required by M.G.L. c.176G, § 4O(b) (as added by St. 2002, c. 49, §§ 4 and 5).

(f) Material to be Submitted: A Health Maintenance Organization which intends to issue Evidences of Coverage Issued Pursuant to a Risk or Cost Contracts to be effective on or after January 1, 1995 must:

1. file such Evidences of Coverage Issued Pursuant to a Risk or Cost Contract which show compliance with 211 CMR 71.23(5) no later than December 1, 1994; and
2. annually, on or before December 1 of each calendar year, file a list identifying each of its risk and cost contracts in Massachusetts to be in effect for the following calendar year, including a specification of contracts which cover health care prepayment plans. For each such contract, include a description of benefits, rates, service area and number of Members.

(g) A Health Maintenance Organization may request a waiver from the requirements of 211 CMR 71.23(5)(b) from the Commissioner permitting a one-year extension of time to comply for good cause shown if that HMO is unable to comply with the provisions of 211 CMR 71.23(5)(b) by January 1, 1995. Such a waiver shall be granted only for the purpose of preventing unavoidable disruption to coverage to Members or potential Members. If such a waiver is granted, the Health Maintenance Organization will only be allowed to offer an Evidence of Coverage Issued Pursuant to a Risk or Cost Contract to be originally effective from January 1, 1995 through December 31, 1995 which does not contain any Outpatient Prescription Drug benefit. A Health Maintenance Organization seeking such a waiver shall submit a request for a waiver no later than November 1, 1994. A request for a waiver shall include the following information:

1. identification of any risk or cost contracts which have been entered into for the calendar year 1995;

2. an explanation regarding why the contracts identified in accordance with 211 CMR 71.23(g)1. cannot be modified or why new risk or cost contracts cannot be entered into for the calendar year 1995 in order to comply with 211 CMR 71.23(5)(b) by January 1, 1995, including a demonstration of due diligence in seeking a risk or cost contract with the benefits required in 211 CMR 71.23(5)(b); and

3. any other circumstances which the Health Maintenance Organization considers to be extenuating.

(6) The terms "Medicare Supplement," "Medigap" and words of similar import shall not be used to describe an Evidence of Coverage Issued Pursuant to a Risk or Cost Contract.

(7) Any Health Maintenance Organization whose risk or cost contract with Medicare is being terminated shall give to following parties at least 60 days notice prior to such termination: the Commissioner of Insurance, each Member who is covered under an Evidence of Coverage Issued Pursuant to such Risk or Cost Contract, each Health Maintenance Organization Participating in the market for Evidences of Coverage Issued Pursuant to a Risk or Cost Contract and each Issuer participating in the market for Medicare Supplement Insurance. Any such Health Maintenance Organization shall cooperate fully in the prompt transfer of coverage to any organization which will assume such coverage and any open enrollment period scheduled pursuant to 211 CMR 71.10(6) and (7).

(8) (a) Any Health Maintenance Organization which undergoes a termination of all of its risk or cost contracts with Medicare on or after January 1, 1995 shall be deemed to have withdrawn from the market and may not Participate in the Market for Evidences of Coverage Issued Pursuant to a Risk or Cost Contract for five years from the date of withdrawal, unless the Health Maintenance Organization can demonstrate that Medicare is willing to contract with such Health Maintenance Organization and the Commissioner of Insurance finds that the HMO's re-entry into the market shall be permitted earlier than five years due to a compelling public interest. An HMO shall not be deemed to have withdrawn from the market if, at the time the HMO terminates all of its risk or cost contracts with Medicare, it notifies the Commissioner in writing that such termination is made in order that the HMO may change its financial arrangement with Medicare from a risk contract to a cost contract or health care prepayment plan, or from a cost contract or health care prepayment plan to a risk contract.

(b) For the purposes of 211 CMR 71.23(8)(a), "Withdraw or Withdrawal from the Market" shall mean that the Health Maintenance Organization has discontinued the availability of all of its Evidences of Coverage Issued Pursuant to a Risk or Cost Contract in accordance with 211 CMR 71.23(8).

(c) For the purposes of 211 CMR 71.23(8)(a), the "Date of Withdrawal" shall mean the last date which the Health Maintenance Organization had in effect any Evidence of Coverage Issued Pursuant to a Risk or Cost Contract on or after January 1, 1995 in Massachusetts.

(9) Health Maintenance Organizations shall continue to renew Evidences of Coverage Issued Pursuant to a Risk or Cost Contract originally made effective prior to January 1, 1995, if required under the terms and conditions of those Evidences of Coverage, and may renew such Evidences of Coverage to the extent such renewal is not required under the terms and conditions of those Evidences of Coverage.

71.24: Annual Public Hearing to Monitor Market Condition

(1) The Commissioner shall annually conduct a public hearing to monitor the overall condition of the Massachusetts market so as to improve access by individuals to coverage under 211 CMR 71.00, *et seq*., to encourage aggregation of risk pools through product selection and to promote long-term access by individuals to coverage through continued stability and financial viability of all carriers in the market. Such hearing shall be conducted during the month of June each year commencing with June 1995, unless otherwise determined by the Commissioner. Interested parties are encouraged to suggest issues to be addressed at the hearing by filing a request with the Commissioner no later than April 15 of each year, commencing with April15,1995.

(2) The Commissioner shall also file with the committee on insurance any recommendations for legislation to improve the accessibility and affordability of coverage in the market.

71.89: Severability

If any section or portion of a section of 211 CMR 71.00, or the applicability thereof to any person or circumstance is held invalid by any court of competent jurisdiction, the remainder of 211 CMR 71.00, or the applicability thereof to other persons or circumstances, shall not be affected thereby.

71.90: Appendix A - Medicare Supplement Core

A Medicare Supplement Core Insurance Policy shall provide the following coverage and shall not provide any additional benefits:

(1) The following Medicare Part A eligible expenses:
(a.) To the extent not covered by Medicare, benefits for hospitalization for the first 90 days per benefit period less the Medicare Part A deductible, plus 60 lifetime reserve days, then an additional lifetime maximum of 365 days paid at the Diagnostic Related Group (DRG) day outlier per diem or other appropriate standard of payment. Such benefits shall include treatment for biologically-based mental disorders and charges for the first three pints of blood.
(b.) To the extent not covered by Medicare, for biologically-based mental disorders, stays in a licensed mental hospital, less Part A deductibles; for other mental disorders benefits, stays in a licensed mental hospital for at least 60 days per calendar year less days covered by Medicare or already covered by the plan in that calendar year for other mental disorders, less Part A deductibles.

(2) The following Medicare Part B eligible expenses: To the extent not covered by Medicare, the Medicare Part B coinsurance or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equivalent to the Medicare Part B deductible [$100]. This includes all costs for the first three pints of blood.

(3) Services rendered for the treatment of mental disorders on an outpatient basis:
a. For biologically-based mental disorders:
1. By a provider covered by Medicare, the benefit described in 211 CMR 71.90(2).
2. By a provider not covered by Medicare, coverage for all medically necessary visits.
b. For other mental health disorders:
1. By a provider covered by Medicare, the benefit described in 211 CMR 71.90(2).

2. By a provider not covered by Medicare, a minimum of 24 medically necessary visits per 12-month period, less any visits already covered under 211 CMR 71.90(3)(a)(1), in the 12-month period.

As required by M.G.L. c. 175, § 47B(i), M.G.L. c. 176A, § 8A(i), M.G.L. c. 176B §4A(i), psychopharmacological services and neuropsychological assessment services shall be treated as a medical benefit and shall be covered as described in 211 CMR 71.90(2).

(4) (a) Enteral formulas medically necessary for the treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, as required by M.G.L. c. 175, § 47I; M.G.L. c. 176A, § 8L; and M.G.L. c. 176B, § 4K, as amended from time to time, less any Medicare payments.

(b) Enteral formulas medically necessary for the treatment of inherited diseases of amino acids and organic acids as required by M.G.L. c. 175, § 47I, M.G.L. c. 176A, § 8L; and M.G.L. c. 176B, § 4K, as amended from time to time, less any Medicare payments. Coverage for inherited disease of amino acids and organic acids shall include food products modified to be low protein in an amount not to exceed $2,500 annually for any Insured individual.

(5) Where applicable, as required under M.G.L. c. 175, § 47G, as amended from time to time, pap smear tests and mammograms not covered by Medicare.

(6) Bone marrow transplants or transplants for certain patients with breast cancer as required by M.G.L. c. 175, § 47M; M.G.L. c. 176A, § 8O (as added by St. 1993, c. 458, § 2); and M.G.L. c. 176B, § 4O, as amended from time to time, not covered by Medicare.

(7) At the option of the Issuer, and if approved by the Commissioner, the New Benefit outlined in 211 CMR 71.09(1) and (1)(a).

(8) The addition or deletion of any benefits that are mandated by Massachusetts law on or after the original effective date of this Medicare Supplement Core Policy.

(9) Blood-glucose monitoring strips for home use for which a physician has issued a written order and which are medically necessary for the treatment of insulin dependent diabetes.

(10)Licensed hospice services to terminally ill patients with a life expectancy of six months or less, as set forth and regulated by M.G.L. c. 111, § 57D and as authorized by a duly licensed physician as required by M.G.L. c. 175, § 47Q (as added by St. 1994, c. 284, § 2); M.G.L. c. 176A, § 8P (as added by St. 1994, c. 284, § 3); and M.G.L. c. 176B, § 4Q (as added by St. 1994, c. 284, § 4), as amended from time to time.

(11) Expenses incurred in the medically necessary diagnosis and treatment of speech, hearing and language disorders individuals licensed as speech-language pathologists or audiologists under M.G.L. c. 112, as required by M.G.L. c. 175, § 47U (as added by St. 2000, c. 345, § 2); M.G.L. c. 176A, § 8U (as added by St. 2000, c. 345, § 3); and M.G.L. c. 176B, § 4U (as added by St. 2000, c. 345, § 4).

(12) Hormone replacement therapy services for peri and post menopausal women and outpatient contraceptive services under the same terms and conditions as for such other outpatient services. Outpatient contraceptive services shall mean consultations, examinations, procedures and medical services provided on an outpatient basis and related to the use of all contraceptive methods to prevent pregnancy that have been approved by the United States Food and Drug Administration, as required by M.G.L. c. 175, § 47W(a) (as added by St. 2002, c. 49, §1); M.G.L. c. 176A, §

8W(a) (as added by St. 2002, c. 49, §2) and M.G.L. c. 176B, § 4W(a) (as added by St. 2002, c. 49, §3).

71.91: Appendix B - Medicare Supplement 1

A Medicare Supplement 1 Insurance Policy shall provide the following coverage and shall not provide any additional benefits:

(1) The following Medicare Part A eligible expenses:

(a) To the extent not covered by Medicare, benefits for hospitalization for the first 90 days per benefit period, plus 60 lifetime reserve days, then an additional lifetime maximum of 365 days paid at the Diagnostic Related Group (DRG) day outlier per diem or other appropriate standard of payment. Such benefits shall include treatment for biologically-based mental disorders and charges for the first three pints of blood.

(b) To the extent not covered by Medicare, for biologically-based mental disorders, stays in a licensed mental hospital; for other mental disorders benefits, stays in a licensed mental hospital for a minimum of 120 days per benefit period (at least 60 days per calendar year) less days covered by Medicare or already covered by the plan in that calendar year for other mental disorders.

(c) Services in a skilled nursing facility certified by Medicare, during the first 100 days, to the extent not covered by Medicare, and $10 per day for the l01st through the 365th day per benefit period, provided the stay otherwise meets Medicare requirements. Benefits for services in all skilled nursing facilities shall be available for a combined maximum of 365 days per benefit period.

(2) Services in a skilled nursing facility not certified by Medicare at $8 per day for 365 days per benefit period, provided the admission otherwise meets Medicare requirements. Benefits for services in all skilled nursing facilities shall be available for a combined maximum of 365 days per benefit period.

(3) The following Medicare Part B eligible expenses: To the extent not covered by Medicare, the Medicare Part B deductible and coinsurance or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount for Medicare Part B eligible expenses regardless of hospital confinement. This includes all costs for the first three pints of blood.

(4) Services rendered for the treatment of mental disorders on an outpatient basis:

a. For biologically-based mental disorders:

1. By a provider covered by Medicare, the benefit described in 211 CMR 71.91(3).
2. By a provider not covered by Medicare, coverage for all medically necessary visits.

b. For other mental health disorders:

1. By a provider covered by Medicare, the benefit described in 211 CMR 71.91(3).
2. By a provider not covered by Medicare, a minimum of 24 medically necessary visits per 12-month period, less any visits already covered under 211 CMR 71.91(4)(a)(1), in the 12-month period.

.As required by M.G.L. c. 175, § 47B(i), M.G.L. c. 176A, § 8A(i), M.G.L. c. 176B §4A(i), psychopharmacological services and neuropsychological assessment services shall be treated as a medical benefit and shall be covered as described in 211 CMR 71.91(3).

(5) (a) Enteral formulas medically necessary for the treatment of malabsorption caused by

Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, as required by M.G.L. c. 175, § 47I; M.G.L. c. 176A, § 8L and M.G.L. c. 176B, § 4K, as amended from time to time, less any Medicare payments.

(b) Enteral formulas medically necessary for the treatment of inherited diseases of amino acids and organic acids as required by M.G.L. c. 175, § 47I; M.G.L. c. 176A, § 8L; and M.G.L. c. 176B, § 4K, as amended from time to time, less any Medicare payments. Coverage for inherited disease of amino acids and organic acids shall include food products modified to be low protein in an amount not to exceed $2,500 annually for any Insured individual.

(6) The Medicare daily skilled nursing facility coinsurance for Christian Science Sanatorium nursing services up to 30 days per benefit period.

(7) For those traveling outside the United States, and its territories, coverage for the same services and the same level of payment as is provided within the United States by the combination of Medicare Part A and Part B and the Medicare Supplement 1 Insurance Policy less any Medicare payments.

(8) Annual pap smear tests and mammograms not covered by Medicare.

(9) Non-Medicare covered services rendered by a dentist during a Medicare-eligible admission for those services.

(10) Bone marrow transplants or transplants for certain patients with breast cancer as required by M.G.L. c. 175, § 47M; M.G.L. c. 176A, § 8O (as added by St. 1993, c. 458, § 2); and M.G.L. c. 176B, § 4O, as amended from time to time, when not covered by Medicare.

(11) At the option of the Issuer, and if approved by the Commissioner, the New Benefit outlined in 211 CMR 71.09(1) and (1)(a).

(12) The addition or deletion of any benefits that are mandated by Massachusetts law on or after the original effective date of this Medicare Supplement 1 Policy.

(13) Blood-glucose monitoring strips for home use for which a physician has issued a written order and which are medically necessary for the treatment of insulin dependent diabetes.

(14) Licensed hospice services to terminally ill patients with a life expectancy of six months or less, as set forth and regulated by M.G.L. c. 111, § 57D and as authorized by a duly licensed physician as required by M.G.L. c. 175, § 47Q (as added by St. 1994, c. 284, § 2); M.G.L. c. 176A, § 8P (as added by St. 1994, c. 284, § 3); and M.G.L. c. 176B, § 4Q (as added by St. 1994, c. 284, § 4), as amended from time to time.

(15) Expenses incurred in the medically necessary diagnosis and treatment of speech, hearing and language disorders individuals licensed as speech-language pathologists or audiologists under M.G.L. c. 112, as required by M.G.L. c. 175, § 47U (as added by St. 2000, c. 345, § 2); M.G.L. c. 176A, § 8U (as added by St. 2000, c. 345, § 3); and M.G.L. c. 176B, § 4U (as added by St. 2000, c. 345, § 4).

(16) Hormone replacement therapy services for peri and post menopausal women and outpatient contraceptive services under the same terms and conditions as for such other outpatient services. Outpatient contraceptive services shall mean consultations, examinations, procedures and medical services provided on an outpatient basis and related to the use of all contraceptive methods to

prevent pregnancy that have been approved by the United States Food and Drug Administration, as required by M.G.L. c. 175, § 47W(a) (as added by St. 2002, c. 49, §1); M.G.L. c. 176A, § 8W(a) (as added by St. 2002, c. 49, § 2) and M.G.L. c. 176B, § 4W(a) (as added by St. 2002, c. 49, § 3).

71.92: Appendix C - Medicare Supplement 2

A Medicare Supplement 2 Insurance Policy shall provide the following coverage and shall not provide any additional benefits:

(1) The following Medicare Part A eligible expenses:

(a) To the extent not covered by Medicare, benefits for hospitalization for the first 90 days per benefit period, plus 60 lifetime reserve days, then an additional lifetime maximum of 365 days paid at the Diagnostic Related Group (DRG) day outlier per diem or other appropriate standard of payment. Such benefits shall include benefits for biologically-based mental health disorders and charges for the first three pints of blood.

(b) To the extent not covered by Medicare, for biologically-based mental disorders, stays in a licensed mental hospital; for other mental disorders benefits, stays in a licensed mental hospital for a minimum of 120 days per benefit period (at least 60 days per calendar year) less days covered by Medicare or already covered by the plan in that calendar year for other mental disorders.

(c) Services in a skilled nursing facility certified by Medicare, during the first 100 days, to the extent not covered by Medicare, and $10 per day for the 101st through the 365th day per benefit period, provided the stay otherwise meets Medicare requirements. Benefits for services in all skilled nursing facilities shall be available for a combined maximum of 365 days per benefit period.

(2) Services in a skilled nursing facility not certified by Medicare at $8 per day for 365 days per benefit period, provided the admission otherwise meets Medicare requirements. Benefits for services in all skilled nursing facilities shall be available for a combined maximum of 365 days per benefit period.

(3) The following Medicare Part B eligible expenses: To the extent not covered by Medicare, the Medicare Part B deductible and coinsurance or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount for Medicare Part B eligible expenses regardless of hospital confinement. This includes all costs for the first three pints of blood.

(4) Services rendered for the treatment of mental disorders on an outpatient basis:

a. For biologically-based mental health disorders:

1. By a provider covered by Medicare, the benefit described in 211 CMR 71.92(3).
2. By a provider not covered by Medicare, coverage for all medically necessary visits.

b. For other mental health disorders:

1. By a provider covered by Medicare, the benefit described in 211 CMR 71.92(3).
2. By a provider not covered by Medicare, a minimum of 24 medically necessary visits per 12-month period, less any visits already covered under 211 CMR 71.92(4)(a)(1), in the 12-month period.

As required by M.G.L. c. 175, § 47B(i), M.G.L. c. 176A, § 8A(i), M.G.L. c. 176B §4A(i), psychopharmacological services and neuropsychological assessment services shall be treated as a medical benefit and shall be covered as described in 211 CMR 71.92(3).

(5) (a) Enteral formulas medically necessary for the treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, as required by M.G.L. c. 175, § 47I; M.G.L. c. 176A, § 8L; and M.G.L. c. 176B, § 4K, as amended from time to time, less any Medicare payments.

(b) Enteral formulas medically necessary for the treatment of inherited diseases of amino acids and organic acids as required by M.G.L. c. 175, § 47I; M.G.L. c. 176A, § 8L; and M.G.L. c. 176B, § 4K, as amended from time to time, less any Medicare payments. Coverage for inherited disease of amino acids and organic acids shall include food products modified to be low protein in an amount not to exceed $2,500 annually for any Insured individual.

(6) The Medicare daily skilled nursing facility coinsurance for Christian Science Sanatorium nursing services up to 30 days per benefit period.

(7) For those traveling outside the United States and its territories, coverage for the same services and the same level of payment as is provided within the United States by the combination of Medicare Part A and Part B and the Medicare Supplement 2 Insurance Policy.

(8) Annual pap smear tests and mammograms not covered by Medicare.

(9) Non-Medicare covered services rendered by a dentist during a Medicare-eligible admission for those services.

(10) Bone marrow transplants or transplants for certain patients with breast cancer as required by M.G.L. c. 175, § 47M; M.G.L. c. 176A, § 8O (as added by St. 1993, c. 458, § 2); and M.G.L. c. 176B, § 4O, as amended from time to time, when not covered by Medicare.

(11) The following benefits for Outpatient Prescription Drugs: coverage for 80% of either charges or allowed charges for brand name drugs, and 100% of either charges or allowed charges for generic drugs, for which federal law requires a prescription, in excess of a calendar quarter deductible. The calendar quarter deductible shall be $35.

For the purposes of 211 CMR 71.92, "Outpatient Prescription Drugs" includes insulin, as well as the needles, syringes, pumps and pump supplies necessary for the administration of insulin and blood sugar level testing equipment and supplies for use at home; drugs provided by a home infusion therapy provider; and drugs used on an off-label basis for the treatment of cancer or HIV/AIDS and medically necessary services associated with the administration of such drugs as required by M.G.L. c. 175, § 47K; M.G.L. c. 175, § 47L; M.G.L. c. 176A, § 8N; and M.G.L. c. 176B, § 4N, as amended from time to time, or by M.G.L. c. 175, § 47O; M.G.L. c. 175, § 47P; M.G.L. c. 176A, § 8O (as added by St. 1994, c. 60, § 144); and M.G.L. c. 176B, § 4P (as added by St. 1994, c. 60, § 146), as amended from time to time and drugs and devices for hormone replacement therapy for peri and post menopausal women and for outpatient prescription contraceptive drugs or devices as required by M.G.L. c. 175, § 47W; M.G.L. c. 176A, § 8W and M.G.L. c. 176B, § 4W,(as added by St. 2002, c. 49, §§ 4 and 5).

(12) At the option of the Issuer, and if approved by the Commissioner, the New or Innovative Benefits outlined in 211 CMR 71.09(1), 211 CMR 71.09(1)(a), 211 CMR 71.09(1)(b)1. and 211 CMR 71.09(1)(b)2.

(13) The addition or deletion of any benefits that are mandated by Massachusetts law on or after the original effective date of this Medicare Supplement 2 Policy.

(14) Blood-glucose monitoring strips for home use for which a physician has issued a written order and which are medically necessary for the treatment of insulin dependent diabetes.

(15) Licensed hospice services to terminally ill patients with a life expectancy of six months or less, as set forth and regulated by M.G.L. c. 111, § 57D and as authorized by a duly licensed physician as required by M.G.L. c. 175, § 47Q (as added by St. 1994, c. 284, § 2); M.G.L. c. 176A, § 8P (as added by St. 1994, c. 284, § 3); and M.G.L. c. 176B, § 4Q (as added by St. 1994, c. 284, § 4), as amended from time to time.

(16) Expenses incurred in the medically necessary diagnosis and treatment of speech, hearing and language disorders individuals licensed as speech-language pathologists or audiologists under M.G.L. c. 112, as required by M.G.L. c. 175, § 47U (as added by St. 2000, c. 345, § 2); M.G.L. c. 176A, § 8U (as added by St. 2000, c. 345, § 3); and M.G.L. c. 176B, § 4U (as added by St. 2000, c. 345, § 4).

(17) Hormone replacement therapy services for peri and post menopausal women and outpatient contraceptive services under the same terms and conditions as for such other outpatient services. Outpatient contraceptive services shall mean consultations, examinations, procedures and medical services provided on an outpatient basis and related to the use of all contraceptive methods to prevent pregnancy that have been approved by the United States Food and Drug Administration, as required by M.G.L. c. 175, § 47W (as added by St. 2002, c. 49, §1); M.G.L. c. 176A, § 8W (as added by St. 2002, c. 49, § 2) and M.G.L. c. 176B, § 4W (as added by St. 2002, c. 49, § 3).

REGULATORY AUTHORITY

211 CMR 71:00: M.G.L. c. 175, §§ 2B, 108, 110E, and 205;
M.G.L. chs. 175J, 176, 176A, 176B, 176D, 176G and 176K.

71.96: Appendix D - Medicare Supplement Refund Calculation Form

MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR_____
PAGE 1

TYPE[1]…….. SMSBP[2]……
For the State of …… Company Name ……
NAIC Group Code…… NAIC Company Code……
Address……. Person Completing Exhibit…….
Title……... Telephone Number…….

Line		(a) Earned Premium[3]	(b) Incurred Claims[4]
1.	Current Year's Experience1		
	a. Total (all policy years)		
	b. Current year's issues[5]		
	c. Net (for reporting purposes = 1.a. –1.b.	_____	_____
2.	Past Years' Experience (all policy years)	_____	_____
		_____	_____
3.	Total Experience (Net Current Year + Past Year)	_____	_____
4.	Refunds Last Year (Excluding Interest)		_____
5.	Previous Refunds Since Inception (Excluding Interest)		_____
6.	Total Refunds Since Inception (Excluding Interest)		_____
7.	Benchmark Ratio Since Inception ("Ratio 1") (Use relevant worksheet in 211 CMR 71.96(A), (B), or (C)(2001-2016))		_____
8.	Experienced Ratio Since Inception ("Ratio 2") Total Actual Incurred Claims (line 3, col. b) / Total Earned Prem. (line 3, col. a) – Total Refunds Since Incep (line 6) =		_____
9.	Life Years Exposed Since Inception If the Experienced Ratio Since Inception ("Ratio 1") is less than the Benchmark Ratio Since Inception ("Ratio 2"), and there are more than 500 life years exposure, then proceed to calculation of refund.		_____

[1]Individual, Group, Individual Medicare Select, or Group Medicare Select Only.
[2]"SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans.

[3] Includes Modal Loadings and Fees Charged
[4]Excludes Active Life Reserves

[5]This is to be used as "Issue Year Earned Premium" for Year 1 of next year's "Worksheet for Calculation of Benchmark Ratios"

MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR_____

TYPE[1]…….. SMSBP[2]……
For the State of …… Company Name ……
NAIC Group Code…… NAIC Company Code……
Address……. Person Completing Exhibit…….
Title……... Telephone Number…….

10. Tolerance Permitted (obtained from credibility table) _____

Medicare Supplement Credibility Table Life Years Exposed

Since Inception	Tolerance
10,000 +	0.0%
5,000 -9,999	5.0%
2,500 -4,999	7.5%
1,000 -2,499	10.0%
500 - 999	15.0%

If less than 500, no credibility.

11. Adjustment to Incurred Claims for Credibility
Ratio 3 = Ratio 2 + Tolerance _____

If Ratio 3 is more than Benchmark Ratio (Ratio 1), a refund or credit to premium is not required.
If Ratio 3 is less than the Benchmark Ratio, then proceed.

12. Adjusted Incurred Claims
[Total Earned Premiums (line 3, col. a)
- Refunds Since Inception (line 6)] X Ratio 3 (line 11) _____

13. Refund
[Total Earned Prem. (line 3, col. a) - Refunds Since Incep (line 6)
- Adjusted Incurred Claims (line 12)] / Benchmark Ratio Since Inception ("Ratio 1") = _____

If the amount on line 13 is less than .005 times the annualized premium in force as of December 31 of the reporting year, then no refund is made. Otherwise, the amount on line 13 is to be refunded or credited, and a description of the refund and/or credit against premiums to be used must be attached to this form.

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

_____
Signature

_____
Name - Please Type

_____
Title - Please Type

_____
Date

[1]Individual, Group, Individual Medicare Select, or Group Medicare Select Only.
[2] "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans.

211 CMR 71.96(A)

REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION FOR GROUP MEDICARE SUPPLEMENT POLICIES ISSUED BY COMMERCIAL ISSUERS FOR CALENDAR YEAR_____

TYPE[1]…….. SMSBP[2]……
For the State of …… Company Name ……
NAIC Group Code…… NAIC Company Code……
Address……. Person Completing Exhibit…….
Title……... Telephone Number…….

(a)	(b)[3] Earned Premium	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o)
			(b)x(c)		(d)x(e)		(b)x(g)		(h)x(i)	
Year		Factor		Cumulative Loss Ratio		Factor		Cumulative Loss Ratio		Policy Year Loss Ratio
1		2.770		0.507		0.000		0.000		0.460
2		4.175		0.567		0.000		0.000		0.630
3		4.175		0.567		1.194		0.759		0.750
4		4.175		0.567		2.245		0.771		0.770
5		4.175		0.567		3.170		0.782		0.800
6		4.175		0.567		3.998		0.792		0.820
7		4.175		0.567		4.754		0.802		0.840
8		4.175		0.567		5.445		0.811		0.870
9		4.175		0.567		6.075		0.818		0.880
10		4.175		0.567		6.650		0.824		0.880
11		4.175		0.567		7.176		0.828		0.880
12		4.175		0.567		7.655		0.831		0.880
13		4.175		0.567		8.093		0.834		0.890
14		4.175		0.567		8.493		0.837		0.890
15		4.175		0.567		8.684		0.838		0.890
			(k):		(l):		(m):		(n):	

Benchmark Ratio Since Inception: (l + n)/(k + m): _____

[1]Group or Group Medicare Select Only.
[2]"SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans.
[3]For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

211 CMR 71.96(B)

REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION FOR INDIVIDUAL MEDICARE SUPPLEMENT POLICIES ISSUED BY COMERCIAL ISSUERS FOR CALENDAR YEAR_____

TYPE[1]…….. SMSBP[2]……
For the State of …… Company Name ……
NAIC Group Code…… NAIC Company Code……
Address……. Person Completing Exhibit…….
Title……... Telephone Number…….

(a)	(b)[3] Earned Premium	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o)
			(b)x(c)		(d)x(e)		(b)x(g)		(h)x(i)	
Year		Factor		Cumulative Loss Ratio		Factor		Cumulative Loss Ratio		Policy Year Loss Ratio
1		2.770		0.442		0.000		0.000		0.400
2		4.175		0.493		0.000		0.000		0.550
3		4.175		0.493		1.194		0.659		0.650
4		4.175		0.493		2.245		0.669		0.670
5		4.175		0.493		3.170		0.678		0.690
6		4.175		0.493		3.998		0.686		0.710
7		4.175		0.493		4.754		0.695		0.730
8		4.175		0.493		5.445		0.702		0.750
9		4.175		0.493		6.075		0.708		0.760
10		4.175		0.493		6.650		0.713		0.760
11		4.175		0.493		7.176		0.717		0.760
12		4.175		0.493		7.655		0.720		0.760
13		4.175		0.493		8.093		0.723		0.770
14		4.175		0.493		8.493		0.725		0.770
15		4.175		0.493		8.684		0.725		0.770
			(k):		(l):		(m):		(n):	

Benchmark Ratio Since Inception: (l + n)/(k + m): _____

[1]Individual or Individual Medicare Select Only.
[2] "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans.
[3]For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

211 CMR 71.96(C)(2001)

1REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION FOR INDIVIDUAL MEDICARE SUPPLEMENT POLICIES ISSUED BY NONPROFIT HOSPITAL SERVICE OR MEDICAL SERVICE CORPORATIONS FOR CALENDAR YEAR 2001

PAGE 1

TYPE[1]…….. SMSBP[2]……
For the State of …… Company Name ……
NAIC Group Code…… NAIC Company Code……
Address……. Person Completing Exhibit…….
Title……... Telephone Number…….

Experience after 2000

(a)	(b)[3] Earned Premium	(c)	(d) (b)x(c)	(e)	(f) (d)x(e)	(g)	(h) (b)x(g)	(i)	(j) (h)x(i)	(o)
Year		Factor		Cumulative Loss Ratio		Factor		Cumulative Loss Ratio		Policy Year Loss Ratio
2000		1.770		0.644		0.000		0.000		0.554
1999		1.405		0.824		0.000		0.000		0.762
1998		0.000		0.000		1.194		0.913		0.900
1997		0.000		0.000		1.051		0.941		0.928
1996		0.000		0.000		0.925		0.968		0.955
1995		0.000		0.000		0.828		0.996		0.983
1994		0.000		0.000		0.756		1.024		1.011
1993		0.000		0.000		0.690		1.045		1.038
1992		0.000		0.000		0.630		1.052		1.052
1991										1.052
1990										1.052
1989										1.066
1988										1.066
1987										1.066
1986										1.066
			(k):		(l):		(m):		(n):	

1

[1]Individual or Individual Medicare Select Only.

[2] "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans.

[3]For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION
FOR INDIVIDUAL MEDICARE SUPPLEMENT POLICIES ISSUED BY
NONPROFIT HOSPITAL SERVICE OR MEDICAL SERVICE CORPORATIONS
FOR CALENDAR YEAR 2001

PAGE 2

TYPE[1]…….. SMSBP[2]……
For the State of …… Company Name ……
NAIC Group Code…… NAIC Company Code……
Address……. Person Completing Exhibit…….
Title……... Telephone Number…….

Experience for year 2000 and prior

(a)	(b)[3] Earned Premium	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o)
			(b)x(c)		(d)x(e)		(b)x(g)		(h)x(i)	
				Cumulative				Cumulative		Policy Year
Year		Factor		Loss Ratio		Factor		Loss Ratio		Loss Ratio
2000		1.000		0.400		0.000		0.000		0.400
1999		2.770		0.442		0.000		0.000		0.550
1998		4.175		0.493		0.000		0.000		0.650
1997		4.175		0.493		1.194		0.659		0.670
1996		4.175		0.493		2.245		0.669		0.690
1995		4.175		0.493		3.170		0.678		0.710
1994		4.175		0.493		3.998		0.686		0.730
1993		4.175		0.493		4.754		0.695		0.750
1992		4.175		0.493		5.444		0.702		0.760
1991										0.760
1990										0.760
1989										0.770
1988										0.770
1987										0.770
1986										0.770
			(o):		(p):		(q):		(r):	

Benchmark Ratio Since Inception: (l + n + p + r)/(k + m + o + q): _____

[1]Individual or Individual Medicare Select Only.
[2] "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans.
[3]For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

211 CMR 71.96(C)(2002)

REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION
FOR INDIVIDUAL MEDICARE SUPPLEMENT POLICIES ISSUED BY
NONPROFIT HOSPITAL SERVICE OR MEDICAL SERVICE CORPORATIONS
FOR CALENDAR YEAR 2002

PAGE 1

TYPE[1]…….. SMSBP[2]……
For the State of …… Company Name ……
NAIC Group Code…… NAIC Company Code……
Address……. Person Completing Exhibit…….
Title……... Telephone Number…….

Experience after 2000

(a)	(b)[3] Earned Premium	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o)
			(b)x(c)		(d)x(e)		(b)x(g)		(h)x(i)	
				Cumulative				Cumulative		Policy Year
Year		Factor		Loss Ratio		Factor		Loss Ratio		Loss Ratio
2001		2.770		0.612		0.000		0.000		0.554
2000		3.175		0.724		0.000		0.000		0.762
1999		1.405		0.824		1.194		0.913		0.900
1998		0.000		0.000		2.245		0.926		0.928
1997		0.000		0.000		1.976		0.953		0.955
1996		0.000		0.000		1.753		0.981		0.983
1995		0.000		0.000		1.584		1.009		1.011
1994		0.000		0.000		1.446		1.034		1.038
1993		0.000		0.000		1.320		1.048		1.052
1992		0.000		0.000		1.206		1.052		1.052
1991										1.052
1990										1.066
1989										1.066
1988										1.066
1987										1.066
			(k):		(l):		(m):		(n):	

[1]Individual or Individual Medicare Select Only.

[2] "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans.

[3]For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION
FOR INDIVIDUAL MEDICARE SUPPLEMENT POLICIES ISSUED BY
NONPROFIT HOSPITAL SERVICE OR MEDICAL SERVICE CORPORATIONS
FOR CALENDAR YEAR 2002

PAGE 2

TYPE[1]…….. SMSBP[2]……
For the State of …… Company Name ……
NAIC Group Code…… NAIC Company Code……
Address……. Person Completing Exhibit…….
Title……... Telephone Number…….

Experience for year 2000 and prior

(a)	(b)[3] Earned Premium	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o)
			(b)x(c)		(d)x(e)		(b)x(g)		(h)x(i)	
				Cumulative				Cumulative		Policy Year
Year		Factor		Loss Ratio		Factor		Loss Ratio		Loss Ratio
2001		0.000		0.000		0.000		0.000		0.400
2000		1.000		0.400		0.000		0.000		0.550
1999		2.770		0.442		0.000		0.000		0.650
1998		4.175		0.493		0.000		0.000		0.670
1997		4.175		0.493		1.194		0.659		0.690
1996		4.175		0.493		2.245		0.669		0.710
1995		4.175		0.493		3.170		0.678		0.730
1994		4.175		0.493		3.998		0.686		0.750
1993		4.175		0.493		4.754		0.695		0.760
1992		4.175		0.493		5.444		0.702		0.760
1991										0.760
1990										0.770
1989										0.770
1988										0.770
1987										0.770
			(o):		(p):		(q):		(r):	

Benchmark Ratio Since Inception: (l + n + p + r)/(k + m + o + q): _____

[1]Individual or Individual Medicare Select Only.
[2] "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans.
[3]For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

211 CMR 71.96(C)(2003)

REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION
FOR INDIVIDUAL MEDICARE SUPPLEMENT POLICIES ISSUED BY
NONPROFIT HOSPITAL SERVICE OR MEDICAL SERVICE CORPORATIONS
FOR CALENDAR YEAR 2003

PAGE 1

TYPE[1]…….. SMSBP[2]……
For the State of …… Company Name ……
NAIC Group Code…… NAIC Company Code……
Address……. Person Completing Exhibit…….
Title……... Telephone Number…….

Experience after 2000

(a)	(b)[3] Earned Premium	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o)
			(b)x(c)		(d)x(e)		(b)x(g)		(h)x(i)	
				Cumulative				Cumulative		Policy Year
Year		Factor		Loss Ratio		Factor		Loss Ratio		Loss Ratio
2002		2.770		0.612		0.000		0.000		0.554
2001		4.175		0.683		0.000		0.000		0.762
2000		3.175		0.724		1.194		0.913		0.900
1999		1.405		0.824		2.245		0.926		0.928
1998		0.000		0.000		3.170		0.938		0.955
1997		0.000		0.000		2.804		0.966		0.983
1996		0.000		0.000		2.509		0.994		1.011
1995		0.000		0.000		2.274		1.020		1.038
1994		0.000		0.000		2.076		1.039		1.052
1993		0.000		0.000		1.896		1.049		1.052
1992		0.000		0.000		1.732		1.054		1.052
1991										1.066
1990										1.066
1989										1.066
1988										1.066
			(k):		(l):		(m):		(n):	

[1]Individual or Individual Medicare Select Only.

[2] "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans.

[3]For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION
FOR INDIVIDUAL MEDICARE SUPPLEMENT POLICIES ISSUED BY
NONPROFIT HOSPITAL SERVICE OR MEDICAL SERVICE CORPORATIONS
FOR CALENDAR YEAR 2003

PAGE 2

TYPE[1]…….. SMSBP[2]……
For the State of …… Company Name ……
NAIC Group Code…… NAIC Company Code……
Address……. Person Completing Exhibit…….
Title……... Telephone Number…….

Experience for year 2000 and prior

(a)	(b)[3] Earned Premium	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o)
			(b)x(c)		(d)x(e)		(b)x(g)		(h)x(i)	
Year		Factor		Cumulative Loss Ratio		Factor		Cumulative Loss Ratio		Policy Year Loss Ratio
2002		0.000		0.000		0.000		0.000		0.400
2001		0.000		0.000		0.000		0.000		0.550
2000		1.000		0.400		0.000		0.000		0.650
1999		2.770		0.442		0.000		0.000		0.670
1998		4.175		0.493		0.000		0.000		0.690
1997		4.175		0.493		1.194		0.659		0.710
1996		4.175		0.493		2.245		0.669		0.730
1995		4.175		0.493		3.170		0.678		0.750
1994		4.175		0.493		3.998		0.686		0.760
1993		4.175		0.493		4.754		0.695		0.760
1992		4.175		0.493		5.444		0.702		0.760
1991										0.770
1990										0.770
1989										0.770
1988										0.770
			(o):		(p):		(q):		(r):	

Benchmark Ratio Since Inception: (l + n + p + r)/(k + m + o + q): _____

[1]Individual or Individual Medicare Select Only.
[2] "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans.
[3]For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

211 CMR 71.96(C)(2004)

REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION
FOR INDIVIDUAL MEDICARE SUPPLEMENT POLICIES ISSUED BY
NONPROFIT HOSPITAL SERVICE OR MEDICAL SERVICE CORPORATIONS
FOR CALENDAR YEAR 2004

PAGE 1

TYPE[1]…….. SMSBP[2]……
For the State of …… Company Name ……
NAIC Group Code…… NAIC Company Code……
Address……. Person Completing Exhibit…….
Title……... Telephone Number…….

Experience after 2000

(a)	(b)[3] Earned Premium	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o)
			(b)x(c)		(d)x(e)		(b)x(g)		(h)x(i)	
				Cumulative				Cumulative		Policy Year
Year		Factor		Loss Ratio		Factor		Loss Ratio		Loss Ratio
2003		2.770		0.612		0.000		0.000		0.554
2002		4.175		0.683		0.000		0.000		0.762
2001		4.175		0.683		1.194		0.913		0.900
2000		3.175		0.724		2.245		0.926		0.928
1999		1.405		0.824		3.170		0.938		0.955
1998		0.000		0.000		3.998		0.950		0.983
1997		0.000		0.000		3.560		0.978		1.011
1996		0.000		0.000		3.199		1.005		1.038
1995		0.000		0.000		2.904		1.027		1.052
1994		0.000		0.000		2.652		1.042		1.052
1993		0.000		0.000		2.422		1.051		1.052
1992		0.000		0.000		2.212		1.057		1.066
1991										1.066
1990										1.066
1989										1.066
			(k):		(l):		(m):		(n):	

[1]Individual, or Individual Medicare Select Only.
[2] "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans.
[3]For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION
FOR INDIVIDUAL MEDICARE SUPPLEMENT POLICIES ISSUED BY
NONPROFIT HOSPITAL SERVICE OR MEDICAL SERVICE CORPORATIONS
FOR CALENDAR YEAR 2004

PAGE 2

TYPE[1]…….. SMSBP[2]……
For the State of …… Company Name ……
NAIC Group Code…… NAIC Company Code……
Address……. Person Completing Exhibit…….
Title……... Telephone Number…….

Experience for year 2000 and prior

(a)	(b)[3] Earned Premium	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o)
			(b)x(c)		(d)x(e)		(b)x(g)		(h)x(i)	
Year		Factor		Cumulative Loss Ratio		Factor		Cumulative Loss Ratio		Policy Year Loss Ratio
2003		0.000		0.000		0.000		0.000		0.400
2002		0.000		0.000		0.000		0.000		0.550
2001		0.000		0.000		0.000		0.000		0.650
2000		1.000		0.400		0.000		0.000		0.670
1999		2.770		0.442		0.000		0.000		0.690
1998		4.175		0.493		0.000		0.000		0.710
1997		4.175		0.493		1.194		0.659		0.730
1996		4.175		0.493		2.245		0.669		0.750
1995		4.175		0.493		3.170		0.678		0.760
1994		4.175		0.493		3.998		0.686		0.760
1993		4.175		0.493		4.754		0.695		0.760
1992		4.175		0.493		5.444		0.702		0.770
1991										0.770
1990										0.770
1989										0.770
			(o):		(p):		(q):		(r):	

Benchmark Ratio Since Inception: (l + n + p + r)/(k + m + o + q): _____

[1]Individual or Individual Medicare Select Only.
[2] "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans.
[3]For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

211 CMR 71.96(C)(2005)

REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION
FOR INDIVIDUAL MEDICARE SUPPLEMENT POLICIES ISSUED BY
NONPROFIT HOSPITAL SERVICE OR MEDICAL SERVICE CORPORATIONS
FOR CALENDAR YEAR 2005

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TYPE[1]…….. SMSBP[2]……
For the State of …… Company Name ……
NAIC Group Code…… NAIC Company Code……
Address……. Person Completing Exhibit…….
Title……... Telephone Number…….

Experience after 2000

(a)	(b)[3] Earned Premium	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o)
			(b)x(c)		(d)x(e)		(b)x(g)		(h)x(i)	
				Cumulative				Cumulative		Policy Year
Year		Factor		Loss Ratio		Factor		Loss Ratio		Loss Ratio
2004		2.770		0.612		0.000		0.000		0.554
2003		4.175		0.683		0.000		0.000		0.762
2002		4.175		0.683		1.194		0.913		0.900
2001		4.175		0.683		2.245		0.926		0.928
2000		3.175		0.724		3.170		0.938		0.955
1999		1.405		0.824		3.998		0.950		0.983
1998		0.000		0.000		4.754		0.962		1.011
1997		0.000		0.000		4.250		0.989		1.038
1996		0.000		0.000		3.829		1.013		1.052
1995		0.000		0.000		3.480		1.031		1.052
1994		0.000		0.000		3.178		1.045		1.052
1993		0.000		0.000		2.902		1.054		1.066
1992		0.000		0.000		2.650		1.058		1.066
1991										1.066
1990										1.066
			(k):		(l):		(m):		(n):	

[1]Individual or Individual Medicare Select Only.

[2] "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans.

[3]For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION
FOR INDIVIDUAL MEDICARE SUPPLEMENT POLICIES ISSUED BY
NONPROFIT HOSPITAL SERVICE OR MEDICAL SERVICE CORPORATIONS
FOR CALENDAR YEAR 2005

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TYPE[1]…….. SMSBP[2]……
For the State of …… Company Name ……
NAIC Group Code…… NAIC Company Code……
Address……. Person Completing Exhibit…….
Title……... Telephone Number…….

Experience for year 2000 and prior

(a)	(b)[3] Earned Premium	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o)
			(b)x(c)		(d)x(e)		(b)x(g)		(h)x(i)	
				Cumulative				Cumulative		Policy Year
Year		Factor		Loss Ratio		Factor		Loss Ratio		Loss Ratio
2004		0.000		0.000		0.000		0.000		0.400
2003		0.000		0.000		0.000		0.000		0.550
2002		0.000		0.000		0.000		0.000		0.650
2001		0.000		0.000		0.000		0.000		0.670
2000		1.000		0.400		0.000		0.000		0.690
1999		2.770		0.442		0.000		0.000		0.710
1998		4.175		0.493		0.000		0.000		0.730
1997		4.175		0.493		1.194		0.659		0.750
1996		4.175		0.493		2.245		0.669		0.760
1995		4.175		0.493		3.170		0.678		0.760
1994		4.175		0.493		3.998		0.686		0.760
1993		4.175		0.493		4.754		0.695		0.770
1992		4.175		0.493		5.444		0.702		0.770
1991										0.770
1990										0.770
			(o):		(p):		(q):		(r):	

Benchmark Ratio Since Inception: (l + n + p + r)/(k + m + o + q): _____

[1]Individual or Individual Medicare Select Only.
[2] "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans.
[3]For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

211 CMR 71.96(C)(2006)

REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION
FOR INDIVIDUAL MEDICARE SUPPLEMENT POLICIES ISSUED BY
NONPROFIT HOSPITAL SERVICE OR MEDICAL SERVICE CORPORATIONS
FOR CALENDAR YEAR 2006

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TYPE[1]…….. SMSBP[2]……
For the State of …… Company Name ……
NAIC Group Code…… NAIC Company Code……
Address……. Person Completing Exhibit…….
Title……... Telephone Number…….

Experience after 2000

(a)	(b)[3] Earned Premium	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o)
			(b)x(c)		(d)x(e)		(b)x(g)		(h)x(i)	
				Cumulative				Cumulative		Policy Year
Year		Factor		Loss Ratio		Factor		Loss Ratio		Loss Ratio
2005		2.770		0.612		0.000		0.000		0.554
2004		4.175		0.683		0.000		0.000		0.762
2003		4.175		0.683		1.194		0.913		0.900
2002		4.175		0.683		2.245		0.926		0.928
2001		4.175		0.683		3.170		0.938		0.955
2000		3.175		0.724		3.998		0.950		0.983
1999		1.405		0.824		4.754		0.962		1.011
1998		0.000		0.000		5.444		0.972		1.038
1997		0.000		0.000		4.880		0.997		1.052
1996		0.000		0.000		4.405		1.018		1.052
1995		0.000		0.000		4.006		1.035		1.052
1994		0.000		0.000		3.658		1.048		1.066
1993		0.000		0.000		3.340		1.055		1.066
1992		0.000		0.000		3.050		1.059		1.066
1991										1.066
			(k):		(l):		(m):		(n):	

[1]Individual or Individual Medicare Select Only.
[2] "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans.
[3]For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION
FOR INDIVIDUAL MEDICARE SUPPLEMENT POLICIES ISSUED BY
NONPROFIT HOSPITAL SERVICE OR MEDICAL SERVICE CORPORATIONS
FOR CALENDAR YEAR 2006

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TYPE[1]…….. SMSBP[2]……
For the State of …… Company Name ……
NAIC Group Code…… NAIC Company Code……
Address……. Person Completing Exhibit…….
Title……... Telephone Number…….

Experience for year 2000 and prior

(a)	(b)[3] Earned Premium	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o)
			(b)x(c)		(d)x(e)		(b)x(g)		(h)x(i)	
Year		Factor		Cumulative Loss Ratio		Factor		Cumulative Loss Ratio		Policy Year Loss Ratio
2005		0.000		0.000		0.000		0.000		0.400
2004		0.000		0.000		0.000		0.000		0.550
2003		0.000		0.000		0.000		0.000		0.650
2002		0.000		0.000		0.000		0.000		0.670
2001		0.000		0.000		0.000		0.000		0.690
2000		1.000		0.400		0.000		0.000		0.710
1999		2.770		0.442		0.000		0.000		0.730
1998		4.175		0.493		0.000		0.000		0.750
1997		4.175		0.493		1.194		0.659		0.760
1996		4.175		0.493		2.245		0.669		0.760
1995		4.175		0.493		3.170		0.678		0.760
1994		4.175		0.493		3.998		0.686		0.770
1993		4.175		0.493		4.754		0.695		0.770
1992		4.175		0.493		5.444		0.702		0.770
1991										0.770
			(o):		(p):		(q):		(r):	

Benchmark Ratio Since Inception: (l + n + p + r)/(k + m + o + q): _____

[1]Individual or Individual Medicare Select Only.
[2] "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans.
[3]For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

211 CMR 71.96(C)(2007)

REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION FOR INDIVIDUAL MEDICARE SUPPLEMENT POLICIES ISSUED BY NONPROFIT HOSPITAL SERVICE OR MEDICAL SERVICE CORPORATIONS FOR CALENDAR YEAR 2007

PAGE 1

TYPE[1]…….. SMSBP[2]……

For the State of …… Company Name ……

NAIC Group Code…… NAIC Company Code……

Address……. Person Completing Exhibit…….

Title……... Telephone Number…….

Experience after 2000

(a)	(b)[3] Earned Premium	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o)
			(b)x(c)		(d)x(e)		(b)x(g)		(h)x(i)	
Year		Factor		Cumulative Loss Ratio		Factor		Cumulative Loss Ratio		Policy Year Loss Ratio
2006		2.770		0.612		0.000		0.000		0.554
2005		4.175		0.683		0.000		0.000		0.762
2004		4.175		0.683		1.194		0.913		0.900
2003		4.175		0.683		2.245		0.926		0.928
2002		4.175		0.683		3.170		0.938		0.955
2001		4.175		0.683		3.998		0.950		0.983
2000		3.175		0.724		4.754		0.962		1.011
1999		1.405		0.824		5.444		0.972		1.038
1998		0.000		0.000		6.074		0.981		1.052
1997		0.000		0.000		5.456		1.003		1.052
1996		0.000		0.000		4.931		1.022		1.052
1995		0.000		0.000		4.486		1.038		1.066
1994		0.000		0.000		4.096		1.050		1.066
1993		0.000		0.000		3.740		1.057		1.066
1992		0.000		0.000		3.241		1.060		1.066
			(k):		(l):		(m):		(n):	

[1]Individual or Individual Medicare Select Only.

[2] "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans.

[3]For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION
FOR INDIVIDUAL MEDICARE SUPPLEMENT POLICIES ISSUED BY
NONPROFIT HOSPITAL SERVICE OR MEDICAL SERVICE CORPORATIONS
FOR CALENDAR YEAR 2007

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TYPE[1]…….. SMSBP[2]……

For the State of……. Company Name……..
For the State of …… Company Name ……
Address……. Person Completing Exhibit…….
Title……... Telephone Number…….

Experience for year 2000 and prior

(a)	(b)[3] Earned Premium	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o)
			(b)x(c)		(d)x(e)		(b)x(g)		(h)x(i)	
Year		Factor		Cumulative Loss Ratio		Factor		Cumulative Loss Ratio		Policy Year Loss Ratio
2006		0.000		0.000		0.000		0.000		0.400
2005		0.000		0.000		0.000		0.000		0.550
2004		0.000		0.000		0.000		0.000		0.650
2003		0.000		0.000		0.000		0.000		0.670
2002		0.000		0.000		0.000		0.000		0.690
2001		0.000		0.000		0.000		0.000		0.710
2000		1.000		0.400		0.000		0.000		0.730
1999		2.770		0.442		0.000		0.000		0.750
1998		4.175		0.493		0.000		0.000		0.760
1997		4.175		0.493		1.194		0.659		0.760
1996		4.175		0.493		2.245		0.669		0.760
1995		4.175		0.493		3.170		0.678		0.770
1994		4.175		0.493		3.998		0.686		0.770
1993		4.175		0.493		4.754		0.695		0.770
1992		4.175		0.493		5.444		0.702		0.770
			(o):		(p):		(q):		(r):	

Benchmark Ratio Since Inception: (l + n + p + r)/(k + m + o + q): _____

[1]Individual or Individual Medicare Select Only.
[2] "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans.
[3]For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

211 CMR 71.96(C)(2008)

REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION
FOR INDIVIDUAL MEDICARE SUPPLEMENT POLICIES ISSUED BY
NONPROFIT HOSPITAL SERVICE OR MEDICAL SERVICE CORPORATIONS
FOR CALENDAR YEAR 2008

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TYPE[1]…….. SMSBP[2]……
For the State of …… Company Name ……
NAIC Group Code…… NAIC Company Code……
Address……. Person Completing Exhibit…….
Title……... Telephone Number…….

Experience after 2000

(a)	(b)[3] Earned Premium	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o)
			(b)x(c)		(d)x(e)		(b)x(g)		(h)x(i)	
Year		Factor		Cumulative Loss Ratio		Factor		Cumulative Loss Ratio		Policy Year Loss Ratio
2007		2.770		0.612		0.000		0.000		0.554
2006		4.175		0.683		0.000		0.000		0.762
2005		4.175		0.683		1.194		0.913		0.900
2004		4.175		0.683		2.245		0.926		0.928
2003		4.175		0.683		3.170		0.938		0.955
2002		4.175		0.683		3.998		0.950		0.983
2001		4.175		0.683		4.754		0.962		1.011
2000		3.175		0.724		5.444		0.972		1.038
1999		1.405		0.824		6.074		0.981		1.052
1998		0.000		0.000		6.650		0.987		1.052
1997		0.000		0.000		5.982		1.008		1.052
1996		0.000		0.000		5.411		1.026		1.066
1995		0.000		0.000		4.924		1.041		1.066
1994		0.000		0.000		4.496		1.051		1.066
1993		0.000		0.000		3.931		1.057		1.066
			(k):		(l):		(m):		(n):	

[1]Individual or Individual Medicare Select Only.
[2] "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans.
[3]For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION
FOR INDIVIDUAL MEDICARE SUPPLEMENT POLICIES ISSUED BY
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FOR CALENDAR YEAR 2008

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TYPE[1]…….. SMSBP[2]……
For the State of …… Company Name ……
NAIC Group Code…… NAIC Company Code……
Address……. Person Completing Exhibit…….
Title……... Telephone Number…….

Experience for year 2000 and prior

(a)	(b)[3] Earned Premium	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o)
			(b)x(c)		(d)x(e)		(b)x(g)		(h)x(i)	
Year		Factor		Cumulative Loss Ratio		Factor		Cumulative Loss Ratio		Policy Year Loss Ratio
2007		0.000		0.000		0.000		0.000		0.400
2006		0.000		0.000		0.000		0.000		0.550
2005		0.000		0.000		0.000		0.000		0.650
2004		0.000		0.000		0.000		0.000		0.670
2003		0.000		0.000		0.000		0.000		0.690
2002		0.000		0.000		0.000		0.000		0.710
2001		0.000		0.000		0.000		0.000		0.730
2000		1.000		0.400		0.000		0.000		0.750
1999		2.770		0.442		0.000		0.000		0.760
1998		4.175		0.493		0.000		0.000		0.760
1997		4.175		0.493		1.194		0.659		0.760
1996		4.175		0.493		2.245		0.669		0.770
1995		4.175		0.493		3.170		0.678		0.770
1994		4.175		0.493		3.998		0.686		0.770
1993		4.175		0.493		4.754		0.695		0.770
			(o):		(p):		(q):		(r):	

Benchmark Ratio Since Inception: (l + n + p + r)/(k + m + o + q): _____

[1]Individual or Individual Medicare Select Only.
[2] "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans.
[3]For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION
FOR INDIVIDUAL MEDICARE SUPPLEMENT POLICIES ISSUED BY
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FOR CALENDAR YEAR 2009

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TYPE[1]…….. SMSBP[2]……
For the State of …… Company Name ……
NAIC Group Code…… NAIC Company Code……
Address……. Person Completing Exhibit…….
Title……... Telephone Number…….

Experience after 2000

(a)	(b)[3] Earned Premium	(c)	(d) (b)x(c)	(e)	(f) (d)x(e)	(g)	(h) (b)x(g)	(i)	(j) (h)x(i)	(o)
Year		Factor		Cumulative Loss Ratio		Factor		Cumulative Loss Ratio		Policy Year Loss Ratio
2008		2.770		0.612		0.000		0.000		0.554
2007		4.175		0.683		0.000		0.000		0.762
2006		4.175		0.683		1.194		0.913		0.900
2005		4.175		0.683		2.245		0.926		0.928
2004		4.175		0.683		3.170		0.938		0.955
2003		4.175		0.683		3.998		0.950		0.983
2002		4.175		0.683		4.754		0.962		1.011
2001		4.175		0.683		5.444		0.972		1.038
2000		3.175		0.724		6.074		0.981		1.052
1999		1.405		0.824		6.650		0.987		1.052
1998		0.000		0.000		7.176		0.992		1.052
1997		0.000		0.000		6.642		1.012		1.066
1996		0.000		0.000		5.849		1.029		1.066
1995		0.000		0.000		5.324		1.043		1.066
1994		0.000		0.000		4.687		1.052		1.066
			(k):		(l):		(m):		(n):	

[1]Individual or Individual Medicare Select Only.
[2] "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans.
[3]For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION
FOR INDIVIDUAL MEDICARE SUPPLEMENT POLICIES ISSUED BY
NONPROFIT HOSPITAL SERVICE OR MEDICAL SERVICE CORPORATIONS
FOR CALENDAR YEAR 2009

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TYPE[1]…….. SMSBP[2]……
For the State of …… Company Name ……
NAIC Group Code…… NAIC Company Code……
Address……. Person Completing Exhibit…….
Title……... Telephone Number…….

Experience for year 2000 and prior

(a)	(b)[3] Earned Premium	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o)
			(b)x(c)		(d)x(e)		(b)x(g)		(h)x(i)	
Year		Factor		Cumulative Loss Ratio		Factor		Cumulative Loss Ratio		Policy Year Loss Ratio
2008		0.000		0.000		0.000		0.000		0.400
2007		0.000		0.000		0.000		0.000		0.550
2006		0.000		0.000		0.000		0.000		0.650
2005		0.000		0.000		0.000		0.000		0.670
2004		0.000		0.000		0.000		0.000		0.690
2003		0.000		0.000		0.000		0.000		0.710
2002		0.000		0.000		0.000		0.000		0.730
2001		0.000		0.000		0.000		0.000		0.750
2000		1.000		0.400		0.000		0.000		0.760
1999		2.770		0.442		0.000		0.000		0.760
1998		4.175		0.493		0.000		0.000		0.760
1997		4.175		0.493		1.194		0.659		0.770
1996		4.175		0.493		2.245		0.669		0.770
1995		4.175		0.493		3.170		0.678		0.770
1994		4.175		0.493		3.998		0.686		0.770
			(o):		(p):		(q):		(r):	

Benchmark Ratio Since Inception: (l + n + p + r)/(k + m + o + q): _____

[1]Individual or Individual Medicare Select Only.
[2] "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans.
[3]For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION
FOR INDIVIDUAL MEDICARE SUPPLEMENT POLICIES ISSUED BY
NONPROFIT HOSPITAL SERVICE OR MEDICAL SERVICE CORPORATIONS
FOR CALENDAR YEAR 2010

PAGE 1

TYPE[1]…….. SMSBP[2]……
For the State of …… Company Name ……
NAIC Group Code…… NAIC Company Code……
Address……. Person Completing Exhibit…….
Title……... Telephone Number…….

Experience after 2000

(a)	(b)[3] Earned Premium	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o)
			(b)x(c)		(d)x(e)		(b)x(g)		(h)x(i)	
Year		Factor		Cumulative Loss Ratio		Factor		Cumulative Loss Ratio		Policy Year Loss Ratio
2009		2.770		0.612		0.000		0.000		0.554
2008		4.175		0.683		0.000		0.000		0.762
2007		4.175		0.683		1.194		0.913		0.900
2006		4.175		0.683		2.245		0.926		0.928
2005		4.175		0.683		3.170		0.938		0.955
2004		4.175		0.683		3.998		0.950		0.983
2003		4.175		0.683		4.754		0.962		1.011
2002		4.175		0.683		5.444		0.972		1.038
2001		4.175		0.683		6.074		0.981		1.052
2000		3.175		0.724		6.650		0.987		1.052
1999		1.405		0.824		7.176		0.992		1.052
1998		0.000		0.000		7.656		0.997		1.066
1997		0.000		0.000		6.900		1.016		1.066
1996		0.000		0.000		6.249		1.032		1.066
1995		0.000		0.000		5.515		1.043		1.066
			(k):		(l):		(m):		(n):	

[1]Individual or Individual Medicare Select Only.
[2] "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans.
[3]For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION
FOR INDIVIDUAL MEDICARE SUPPLEMENT POLICIES ISSUED BY
NONPROFIT HOSPITAL SERVICE OR MEDICAL SERVICE CORPORATIONS
FOR CALENDAR YEAR 2010

PAGE 2

TYPE[1]…….. SMSBP[2]……
For the State of …… Company Name ……
NAIC Group Code…… NAIC Company Code……
Address……. Person Completing Exhibit…….
Title……... Telephone Number…….

Experience for year 2000 and prior

(a)	(b)[3] Earned Premium	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o)
			(b)x(c)		(d)x(e)		(b)x(g)		(h)x(i)	
Year		Factor		Cumulative Loss Ratio		Factor		Cumulative Loss Ratio		Policy Year Loss Ratio
2009		0.000		0.000		0.000		0.000		0.400
2008		0.000		0.000		0.000		0.000		0.550
2007		0.000		0.000		0.000		0.000		0.650
2006		0.000		0.000		0.000		0.000		0.670
2005		0.000		0.000		0.000		0.000		0.690
2004		0.000		0.000		0.000		0.000		0.710
2003		0.000		0.000		0.000		0.000		0.730
2002		0.000		0.000		0.000		0.000		0.750
2001		0.000		0.000		0.000		0.000		0.760
2000		1.000		0.400		0.000		0.000		0.760
1999		2.770		0.442		0.000		0.000		0.760
1998		4.175		0.493		0.000		0.000		0.770
1997		4.175		0.493		1.194		0.659		0.770
1996		4.175		0.493		2.245		0.669		0.770
1995		4.175		0.493		3.170		0.678		0.770
			(o):		(p):		(q):		(r):	

Benchmark Ratio Since Inception: (l + n + p + r)/(k + m + o + q): _____

[1]Individual or Individual Medicare Select Only.
[2] "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans.
[3]For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

211 CMR 71.96(C)(2011)

REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION FOR INDIVIDUAL MEDICARE SUPPLEMENT POLICIES ISSUED BY NONPROFIT HOSPITAL SERVICE OR MEDICAL SERVICE CORPORATIONS FOR CALENDAR YEAR 2011

PAGE 1

TYPE[1]…….. SMSBP[2]……
For the State of …… Company Name ……
NAIC Group Code…… NAIC Company Code……
Address……. Person Completing Exhibit…….
Title……... Telephone Number…….

Experience after 2000

(a)	(b)[3] Earned Premium	(c)	(d) (b)x(c)	(e)	(f) (d)x(e)	(g)	(h) (b)x(g)	(i)	(j) (h)x(i)	(o)
Year		Factor		Cumulative Loss Ratio		Factor		Cumulative Loss Ratio		Policy Year Loss Ratio
2010		2.770		0.612		0.000		0.000		0.554
2009		4.175		0.683		0.000		0.000		0.762
2008		4.175		0.683		1.194		0.913		0.900
2007		4.175		0.683		2.245		0.926		0.928
2006		4.175		0.683		3.170		0.938		0.955
2005		4.175		0.683		3.998		0.950		0.983
2004		4.175		0.683		4.754		0.962		1.011
2003		4.175		0.683		5.444		0.972		1.038
2002		4.175		0.683		6.074		0.981		1.052
2001		4.175		0.683		6.650		0.987		1.052
2000		3.175		0.724		7.176		0.992		1.052
1999		1.405		0.824		7.656		0.997		1.066
1998		0.000		0.000		8.094		1.001		1.066
1997		0.000		0.000		7.300		1.018		1.066
1996		0.000		0.000		6.440		1.033		1.066
			(k):		(l):		(m):		(n):	

[1]Individual or Individual Medicare Select Only.

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[3]For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION
FOR INDIVIDUAL MEDICARE SUPPLEMENT POLICIES ISSUED BY
NONPROFIT HOSPITAL SERVICE OR MEDICAL SERVICE CORPORATIONS
FOR CALENDAR YEAR 2011

PAGE 2

TYPE[1]…….. SMSBP[2]……
For the State of …… Company Name ……
NAIC Group Code…… NAIC Company Code……
Address……. Person Completing Exhibit…….
Title……... Telephone Number…….

Experience for year 2000 and prior

(a)	(b)[3] Earned Premium	(c)	(d) (b)x(c)	(e) Cumulative	(f) (d)x(e)	(g)	(h) (b)x(g)	(i) Cumulative	(j) (h)x(i)	(o) Policy Year
Year		Factor		Loss Ratio		Factor		Loss Ratio		Loss Ratio
2010		0.000		0.000		0.000		0.000		0.400
2009		0.000		0.000		0.000		0.000		0.550
2008		0.000		0.000		0.000		0.000		0.650
2007		0.000		0.000		0.000		0.000		0.670
2006		0.000		0.000		0.000		0.000		0.690
2005		0.000		0.000		0.000		0.000		0.710
2004		0.000		0.000		0.000		0.000		0.730
2003		0.000		0.000		0.000		0.000		0.750
2002		0.000		0.000		0.000		0.000		0.760
2001		0.000		0.000		0.000		0.000		0.760
2000		1.000		0.400		0.000		0.000		0.760
1999		2.770		0.442		0.000		0.000		0.770
1998		4.175		0.493		0.000		0.000		0.770
1997		4.175		0.493		1.194		0.659		0.770
1996		4.175		0.493		2.245		0.669		0.770
			(o):		(p):		(q):		(r):	

Benchmark Ratio Since Inception: (l + n + p + r)/(k + m + o + q): _____

[1]Individual or Individual Medicare Select Only.
[2] "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans.
[3]For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

211 CMR 71.96(C)(2012)

REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION FOR INDIVIDUAL MEDICARE SUPPLEMENT POLICIES ISSUED BY NONPROFIT HOSPITAL SERVICE OR MEDICAL SERVICE CORPORATIONS FOR CALENDAR YEAR 2012

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TYPE[1]…….. SMSBP[2]……
For the State of …… Company Name ……
NAIC Group Code…… NAIC Company Code……
Address……. Person Completing Exhibit…….
Title……... Telephone Number…….

Experience after 2000

(a)	(b)[3] Earned Premium	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o)
			(b)x(c)		(d)x(e)		(b)x(g)		(h)x(i)	
				Cumulative				Cumulative		Policy Year
Year		Factor		Loss Ratio		Factor		Loss Ratio		Loss Ratio
2011		2.770		0.612		0.000		0.000		0.554
2010		4.175		0.683		0.000		0.000		0.762
2009		4.175		0.683		1.194		0.913		0.900
2008		4.175		0.683		2.245		0.926		0.928
2007		4.175		0.683		3.170		0.938		0.955
2006		4.175		0.683		3.998		0.950		0.983
2005		4.175		0.683		4.754		0.962		1.011
2004		4.175		0.683		5.444		0.972		1.038
2003		4.175		0.683		6.074		0.981		1.052
2002		4.175		0.683		6.650		0.987		1.052
2001		4.175		0.683		7.176		0.992		1.052
2000		3.175		0.724		7.656		0.997		1.066
1999		1.405		0.824		8.094		1.001		1.066
1998		0.000		0.000		8.494		1.004		1.066
1997		0.000		0.000		7.491		1.020		1.066
			(k):		(l):		(m):		(n):	

[1]Individual or Individual Medicare Select Only.

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[3]For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION
FOR INDIVIDUAL MEDICARE SUPPLEMENT POLICIES ISSUED BY
NONPROFIT HOSPITAL SERVICE OR MEDICAL SERVICE CORPORATIONS
FOR CALENDAR YEAR 2012

PAGE 2

TYPE[1]…….. SMSBP[2]……
For the State of …… Company Name ……
NAIC Group Code…… NAIC Company Code……
Address……. Person Completing Exhibit…….
Title……... Telephone Number…….

Experience for year 2000 and prior

(a)	(b)[3] Earned Premium	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o)
			(b)x(c)		(d)x(e)		(b)x(g)		(h)x(i)	
				Cumulative				Cumulative		Policy Year
Year		Factor		Loss Ratio		Factor		Loss Ratio		Loss Ratio
2011		0.000		0.000		0.000		0.000		0.400
2010		0.000		0.000		0.000		0.000		0.550
2009		0.000		0.000		0.000		0.000		0.650
2008		0.000		0.000		0.000		0.000		0.670
2007		0.000		0.000		0.000		0.000		0.690
2006		0.000		0.000		0.000		0.000		0.710
2005		0.000		0.000		0.000		0.000		0.730
2004		0.000		0.000		0.000		0.000		0.750
2003		0.000		0.000		0.000		0.000		0.760
2002		0.000		0.000		0.000		0.000		0.760
2001		0.000		0.000		0.000		0.000		0.760
2000		1.000		0.400		0.000		0.000		0.770
1999		2.770		0.442		0.000		0.000		0.770
1998		4.175		0.493		0.000		0.000		0.770
1997		4.175		0.493		1.194		0.659		0.770
			(o):		(p):		(q):		(r):	

Benchmark Ratio Since Inception: (l + n + p + r)/(k + m + o + q): _____

[1]Individual or Individual Medicare Select Only.
[2] "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans.
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211 CMR 71.96(C)(2013)

REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION
FOR INDIVIDUAL MEDICARE SUPPLEMENT POLICIES ISSUED BY
NONPROFIT HOSPITAL SERVICE OR MEDICAL SERVICE CORPORATIONS
FOR CALENDAR YEAR 2013

PAGE 1

TYPE[1]…….. SMSBP[2]……
For the State of …… Company Name ……
NAIC Group Code…… NAIC Company Code……
Address……. Person Completing Exhibit…….
Title……... Telephone Number…….

Experience after 2000

(a)	(b)[3] Earned Premium	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o)
			(b)x(c)		(d)x(e)		(b)x(g)		(h)x(i)	
Year		Factor		Cumulative Loss Ratio		Factor		Cumulative Loss Ratio		Policy Year Loss Ratio
2012		2.770		0.612		0.000		0.000		0.554
2011		4.175		0.683		0.000		0.000		0.762
2010		4.175		0.683		1.194		0.913		0.900
2009		4.175		0.683		2.245		0.926		0.928
2008		4.175		0.683		3.170		0.938		0.955
2007		4.175		0.683		3.998		0.950		0.983
2006		4.175		0.683		4.754		0.962		1.011
2005		4.175		0.683		5.444		0.972		1.038
2004		4.175		0.683		6.074		0.981		1.052
2003		4.175		0.683		6.650		0.987		1.052
2002		4.175		0.683		7.176		0.992		1.052
2001		4.175		0.683		7.656		0.997		1.066
2000		3.175		0.724		8.094		1.001		1.066
1999		1.405		0.824		8.494		1.004		1.066
1998		0.000		0.000		8.685		1.005		1.066
			(k):		(l):		(m):		(n):	

[1]Individual or Individual Medicare Select Only.
[2] "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans.
[3]For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION
FOR INDIVIDUAL MEDICARE SUPPLEMENT POLICIES ISSUED BY
NONPROFIT HOSPITAL SERVICE OR MEDICAL SERVICE CORPORATIONS
FOR CALENDAR YEAR 2013

PAGE 2

TYPE[1]…….. SMSBP[2]……
For the State of …… Company Name ……
NAIC Group Code…… NAIC Company Code……
Address……. Person Completing Exhibit…….
Title……... Telephone Number…….

Experience for year 2000 and prior

(a)	(b)[3] Earned Premium	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o)
			(b)x(c)		(d)x(e)		(b)x(g)		(h)x(i)	
				Cumulative				Cumulative		Policy Year
Year		Factor		Loss Ratio		Factor		Loss Ratio		Loss Ratio
2012		0.000		0.000		0.000		0.000		0.400
2011		0.000		0.000		0.000		0.000		0.550
2010		0.000		0.000		0.000		0.000		0.650
2009		0.000		0.000		0.000		0.000		0.670
2008		0.000		0.000		0.000		0.000		0.690
2007		0.000		0.000		0.000		0.000		0.710
2006		0.000		0.000		0.000		0.000		0.730
2005		0.000		0.000		0.000		0.000		0.750
2004		0.000		0.000		0.000		0.000		0.760
2003		0.000		0.000		0.000		0.000		0.760
2002		0.000		0.000		0.000		0.000		0.760
2001		0.000		0.000		0.000		0.000		0.770
2000		1.000		0.400		0.000		0.000		0.770
1999		2.770		0.442		0.000		0.000		0.770
1998		4.175		0.493		0.000		0.000		0.770
			(o):		(p):		(q):		(r):	

Benchmark Ratio Since Inception: (l + n + p + r)/(k + m + o + q): _____

[1]Individual or Individual Medicare Select Only.
[2] "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans.
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211 CMR 71.96(C)(2014)

REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION
FOR INDIVIDUAL MEDICARE SUPPLEMENT POLICIES ISSUED BY
NONPROFIT HOSPITAL SERVICE OR MEDICAL SERVICE CORPORATIONS
FOR CALENDAR YEAR 2014

PAGE 1

TYPE[1]…….. SMSBP[2]……
For the State of …… Company Name ……
NAIC Group Code…… NAIC Company Code……
Address……. Person Completing Exhibit…….
Title……... Telephone Number…….

Experience after 2000

(a)	(b)[3] Earned Premium	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o)
			(b)x(c)		(d)x(e)		(b)x(g)		(h)x(i)	
Year		Factor		Cumulative Loss Ratio		Factor		Cumulative Loss Ratio		Policy Year Loss Ratio
2013		2.770		0.612		0.000		0.000		0.554
2012		4.175		0.683		0.000		0.000		0.762
2011		4.175		0.683		1.194		0.913		0.900
2010		4.175		0.683		2.245		0.926		0.928
2009		4.175		0.683		3.170		0.938		0.955
2008		4.175		0.683		3.998		0.950		0.983
2007		4.175		0.683		4.754		0.962		1.011
2006		4.175		0.683		5.444		0.972		1.038
2005		4.175		0.683		6.074		0.981		1.052
2004		4.175		0.683		6.650		0.987		1.052
2003		4.175		0.683		7.176		0.992		1.052
2002		4.175		0.683		7.656		0.997		1.066
2001		4.175		0.683		8.094		1.001		1.066
2000		3.175		0.724		8.494		1.004		1.066
1999		1.405		0.824		8.685		1.005		1.066
			(k):		(l):		(m):		(n):	

[1]Individual or Individual Medicare Select Only.
[2] "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans.
[3]For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION
FOR INDIVIDUAL MEDICARE SUPPLEMENT POLICIES ISSUED BY
NONPROFIT HOSPITAL SERVICE OR MEDICAL SERVICE CORPORATIONS
FOR CALENDAR YEAR 2014

PAGE 2

TYPE[1]…….. SMSBP[2]……
For the State of …… Company Name ……
NAIC Group Code…… NAIC Company Code……
Address……. Person Completing Exhibit…….
Title……... Telephone Number…….

Experience for year 2000 and prior

(a)	(b)[3] Earned Premium	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o)
			(b)x(c)		(d)x(e)		(b)x(g)		(h)x(i)	
Year		Factor		Cumulative Loss Ratio		Factor		Cumulative Loss Ratio		Policy Year Loss Ratio
2013		0.000		0.000		0.000		0.000		0.400
2012		0.000		0.000		0.000		0.000		0.550
2011		0.000		0.000		0.000		0.000		0.650
2010		0.000		0.000		0.000		0.000		0.670
2009		0.000		0.000		0.000		0.000		0.690
2008		0.000		0.000		0.000		0.000		0.710
2007		0.000		0.000		0.000		0.000		0.730
2006		0.000		0.000		0.000		0.000		0.750
2005		0.000		0.000		0.000		0.000		0.760
2004		0.000		0.000		0.000		0.000		0.760
2003		0.000		0.000		0.000		0.000		0.760
2002		0.000		0.000		0.000		0.000		0.770
2001		0.000		0.000		0.000		0.000		0.770
2000		1.000		0.400		0.000		0.000		0.770
1999		2.770		0.442		0.000		0.000		0.770
			(o):		(p):		(q):		(r):	

Benchmark Ratio Since Inception: (l + n + p + r)/(k + m + o + q): _____

[1]Individual or Individual Medicare Select Only.
[2] "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans.
[3]For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

211 CMR 71.96(C)(2015)

REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION FOR INDIVIDUAL MEDICARE SUPPLEMENT POLICIES ISSUED BY NONPROFIT HOSPITAL SERVICE OR MEDICAL SERVICE CORPORATIONS FOR CALENDAR YEAR 2015

PAGE 1

TYPE[1]…….. SMSBP[2]……
For the State of …… Company Name ……
NAIC Group Code…… NAIC Company Code……
Address……. Person Completing Exhibit…….
Title……... Telephone Number…….

Experience after 2000

(a)	(b)[3] Earned Premium	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o)
			(b)x(c)		(d)x(e)		(b)x(g)		(h)x(i)	
Year		Factor		Cumulative Loss Ratio		Factor		Cumulative Loss Ratio		Policy Year Loss Ratio
2014		2.770		0.612		0.000		0.000		0.554
2013		4.175		0.683		0.000		0.000		0.762
2012		4.175		0.683		1.194		0.913		0.900
2011		4.175		0.683		2.245		0.926		0.928
2010		4.175		0.683		3.170		0.938		0.955
2009		4.175		0.683		3.998		0.950		0.983
2008		4.175		0.683		4.754		0.962		1.011
2007		4.175		0.683		5.444		0.972		1.038
2006		4.175		0.683		6.074		0.981		1.052
2005		4.175		0.683		6.650		0.987		1.052
2004		4.175		0.683		7.176		0.992		1.052
2003		4.175		0.683		7.656		0.997		1.066
2002		4.175		0.683		8.094		1.001		1.066
2001		4.175		0.683		8.494		1.004		1.066
2000		3.175		0.724		8.685		1.005		1.066
			(k):		(l):		(m):		(n):	

[1]Individual or Individual Medicare Select Only.

[2] "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans.

[3]For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION
FOR INDIVIDUAL MEDICARE SUPPLEMENT POLICIES ISSUED BY
NONPROFIT HOSPITAL SERVICE OR MEDICAL SERVICE CORPORATIONS
FOR CALENDAR YEAR 2015

PAGE 2

TYPE[1]…….. SMSBP[2]……
For the State of …… Company Name ……
NAIC Group Code…… NAIC Company Code……
Address……. Person Completing Exhibit…….
Title……... Telephone Number…….

Experience for year 2000 and prior

(a)	(b)[3] Earned Premium	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o)
			(b)x(c)		(d)x(e)		(b)x(g)		(h)x(i)	
Year		Factor		Cumulative Loss Ratio		Factor		Cumulative Loss Ratio		Policy Year Loss Ratio
2014		0.000		0.000		0.000		0.000		0.400
2013		0.000		0.000		0.000		0.000		0.550
2012		0.000		0.000		0.000		0.000		0.650
2011		0.000		0.000		0.000		0.000		0.670
2010		0.000		0.000		0.000		0.000		0.690
2009		0.000		0.000		0.000		0.000		0.710
2008		0.000		0.000		0.000		0.000		0.730
2007		0.000		0.000		0.000		0.000		0.750
2006		0.000		0.000		0.000		0.000		0.760
2005		0.000		0.000		0.000		0.000		0.760
2004		0.000		0.000		0.000		0.000		0.760
2003		0.000		0.000		0.000		0.000		0.770
2002		0.000		0.000		0.000		0.000		0.770
2001		0.000		0.000		0.000		0.000		0.770
2000		1.000		0.400		0.000		0.000		0.770
			(o):		(p):		(q):		(r):	

Benchmark Ratio Since Inception: (l + n + p + r)/(k + m + o + q): _____

[1]Individual or Individual Medicare Select Only.
[2] "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans.
[3]For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

211 CMR 71.96(C)(2016)

REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION
FOR INDIVIDUAL MEDICARE SUPPLEMENT POLICIES ISSUED BY
NONPROFIT HOSPITAL SERVICE OR MEDICAL SERVICE CORPORATIONS
FOR CALENDAR YEAR_____ [2016 and following]

TYPE[1]…….. SMSBP[2]……
For the State of …… Company Name ……
NAIC Group Code…… NAIC Company Code……
Address……. Person Completing Exhibit…….
Title……... Telephone Number…….

Experience after 2000

(a)	(b)[3] Earned Premium	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o)
			(b)x(c)		(d)x(e)		(b)x(g)		(h)x(i)	
Year		Factor		Cumulative Loss Ratio		Factor		Cumulative Loss Ratio		Policy Year Loss Ratio
1		2.770		0.612		0.000		0.000		0.554
2		4.175		0.683		0.000		0.000		0.762
3		4.175		0.683		1.194		0.913		0.900
4		4.175		0.683		2.245		0.926		0.928
5		4.175		0.683		3.170		0.938		0.955
6		4.175		0.683		3.998		0.950		0.983
7		4.175		0.683		4.754		0.962		1.011
8		4.175		0.683		5.444		0.972		1.038
9		4.175		0.683		6.074		0.981		1.052
10		4.175		0.683		6.650		0.987		1.052
11		4.175		0.683		7.176		0.992		1.052
12		4.175		0.683		7.656		0.997		1.066
13		4.175		0.683		8.094		1.001		1.066
14		4.175		0.683		8.494		1.004		1.066
15		4.175		0.683		8.685		1.005		1.066
			(k):		(l):		(m):		(n):	

Benchmark Ratio Since Inception: (l + n)/(k + m): _____

[1]Individual or Individual Medicare Select Only.
[2]"SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans.
[3]For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

71.97: Appendix E - Form for Reporting Medicare Supplement Policies

FORM FOR REPORTING
MEDICARE SUPPLEMENT POLICIES

Company Name: _____

Address: _____

_____

Phone Number: _____

Due March 1, annually

The purpose of this form is to report the following information on each resident of this state who has in force more than one Medicare Supplement policy or certificate. The information is to be grouped by individual policyholder.

Policy and Certificate #	Date of Issuance

_____
Signature

_____
Name and Title (please type)

_____
Date

71.98: Appendix F - Outline of Coverage, Cover Page

[Company Name]
Outline of Medicare Supplement Coverage - Cover Page:
Benefit Plans_____[insert names of plans being offered]

Medicare Supplement Insurance can be sold in only three standard plans. This chart shows the benefits included in each plan. Every company must make available the "Core" plan and the Medicare Supplement 2 plan. Companies may add certain benefits to the standard benefits, if approved by the Commissioner. Look at each company's materials to find out what benefits, if any, the company has added to the standard benefits for each plan it offers.

Basic Benefits: Included in All Plans.
Hospitalization: Part A coinsurance coverage for the first 90 days per benefit period (not including the Medicare Part A deductible) and the 60 Medicare lifetime reserve days, plus coverage for 365 additional days after Medicare benefits end. This shall also include benefits for biologically-based mental disorders.
Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses), or, in the case of hospital outpatient department services paid under a prospective payment system, applicable copayments. This shall also include benefits for biologically-based mental disorders. Blood: First three pints of blood each year.

Core	**Medicare Supplement 1**	**Medicare Supplement 2**
Standard Benefits	**Standard Benefits**	**Standard Benefits**
Basic Benefits	Basic Benefits	Basic Benefits
Hospitalization: For biologically-based mental disorders, stays in a licensed mental hospital; for other mental disorders: up to 60 days per calendar year less days covered by Medicare or plan.	Hospitalization: For biologically-based mental disorders, stays in a licensed mental hospital; for other mental disorders: up to 120 days per benefit period (at least 60 days per calendar year) less days covered by Medicare or plan.	Hospitalization: For biologically-based mental disorders, stays in a licensed mental hospital; for other mental disorders: up to 120 days per benefit period (at least 60 days per calendar year) less days covered by Medicare or plan.
	Skilled Nursing co-insurance	Skilled Nursing co-insurance
	Part A deductible	Part A deductible
	Part B deductible	Part B deductible
	Foreign Travel	Foreign Travel
		Prescription Drugs: $35 deductible per calendar quarter
Additional Benefits	**Additional Benefits**	**Additional Benefits**
[New or Innovative Benefits]	[New or Innovative Benefits]	[New or Innovative Benefits]
[Premium Information]	[Premium Information]	[Premium Information]

71.99: Appendix G - Outline of Coverage, Charts

MEDICARE SUPPLEMENT CORE
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general hospital nursing and miscellaneous services and supplies and licensed mental hospital stays for biologically-based mental disorders or other mental disorders prior to the 190-day Medicare lifetime maximum			
First 60 days of a benefit period	All but $[792]	$0	$[792] Part A Deductible
61st through 90th day of a benefit period	All but $[198] a day	$[198] a day	$0
91st day and after of a benefit period:			
- While using 60 lifetime reserve days	All but $[396] a day	$[396] a day	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare eligible expenses	$0
- Beyond the additional 365 days	$0	$0	All Costs
Licensed mental hospital stays not covered by Medicare for biologically-based mental disorders			
First 60 days of a benefit period	$0	All but $[792]	$[792] Part A Deductible
61st through 90th day of a benefit period	$0	100% of Medicare eligible expenses	$0
91st day and after of a benefit period:			
- While using 60 lifetime reserve days	$0	100% of Medicare eligible expenses	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare eligible expenses	$0
- Beyond the additional 365 days	$0	$0	All Costs

MEDICARE SUPPLEMENT CORE
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD (continued)

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Licensed mental hospital stays not covered by Medicare for other mental disorders :			
First 60 days of a benefit period	$0	All but $[792]	$[792] Part A Deductible
61st day and after of a benefit period	$0	100% of Medicare eligible expenses	$0
- Days after 60 days per calendar year less days covered by Medicare or plan in that calendar year	$0	$0	All Costs
SKILLED NURSING FACILITY CARE*			
(Participating with Medicare) You must meet Medicare's requirements including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after having left the hospital			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $[99] a day	$0	Up to $[99] a day
101st day and after	$0	$0	All Costs

MEDICARE SUPPLEMENT CORE
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD (continued)

BLOOD			
First 3 pints	$0	3 Pints	$0
Additional amounts	100%	$0	$0

HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	Coinsurance	$0

MEDICARE SUPPLEMENT CORE
MEDICARE (PART B) MEDICAL SERVICES - PER CALENDAR YEAR

**Once you have been billed $100 of Medicare-approved amounts for covered services (which are noted with a double asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests and durable medical equipment			
First $100 of Medicare-approved amounts**	$0	$0	$100 (Part B Deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Outpatient treatment for biologically-based mental disorders (for services covered by Medicare)			
First $100 of Medicare-approved amounts**	$0	$0	$100 (Part B Deductible)
Remainder of Medicare-approved amounts	50%	50%	$0
Outpatient treatment for biologically-based mental disorders (for services not covered by Medicare)	$0	100% of expenses	$0
Outpatient treatment for other mental health disorders (for services covered by Medicare)			
First $100 of Medicare-approved amounts**	$0	$0	$100 (Part B Deductible)
Remainder of Medicare-approved amounts	50%	50%	$0
Outpatient treatment for other mental health disorders (for services not covered by Medicare)			
First 24 visits per calendar year	$0	100%	$0
Visits 25 and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare-approved amounts**	$0	$0	$100 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES- BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

MEDICARE (PART B) MEDICAL SERVICES - PER CALENDAR YEAR (continued)

SPECIAL MANDATED MEDICAL FORMULAS			
Covered by Medicare			
First $100 of Medicare-approved amounts**	$0	$0	$100 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
Not covered by Medicare	$0	All allowed charges	Balance

MEDICARE SUPPLEMENT CORE
MEDICARE (PARTS A & B)

**Once you have been billed $100 of Medicare-approved amounts for covered services (which are noted with a double asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE			
Medicare-approved services			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
First $100 of Medicare-approved amounts**	$0	$0	$100 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
OUTPATIENT PRESCRIPTION DRUGS NOT COVERED BY MEDICARE	$0	$0	All costs
[ANY NEW OR INNOVATIVE BENEFITS OFFERED BY ISSUER SHALL BE DESCRIBED HERE]			

MEDICARE SUPPLEMENT 1
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general hospital nursing and miscellaneous services and supplies and licensed mental hospital stays for biologically-based mental disorders or other mental disorders prior to the 190-day Medicare lifetime maximum			
First 60 days of a benefit period	All but $[792]	$[792] (Part A Deductible)	$0
61st through 90th day of a benefit period	All but $[198] a day	$[198] a day	$0
91st day and after of a benefit period:			
- While using 60 lifetime reserve days	All but $[396] a day	$[396] a day	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare eligible expenses	$0
- Beyond the additional 365 days	$0	$0	All Costs
Licensed mental hospital stays for biologically-based mental disorders not covered by Medicare			
First 60 days of a benefit period	$0	100% of Medicare eligible expenses	$0
61st through 90th day of a benefit period	$0	100% of Medicare eligible expenses	$0
91st day and after of a benefit period:			
- While using 60 lifetime reserve days	$0	100% of Medicare eligible expenses	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare eligible expenses	$0
- Beyond the additional 365 days	$0	$0	All Costs

MEDICARE SUPPLEMENT 1
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD (continued)

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Licensed mental hospital stays not covered by Medicare for other mental disorders :			
- First 120 days per benefit period (at least 60 days per calendar year) less days covered by Medicare or plan in that calendar year			
First 60 days of a benefit period	$0	100% of Medicare eligible expenses	$0
61st through 120th day of a benefit period	$0	100% of Medicare eligible expenses	$0
- Days after 120 days per benefit period (or 60 days per calendar year) less days covered by Medicare or plan in that calendar year	$0	$0	All Costs

MEDICARE SUPPLEMENT 1
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD (continued)

SKILLED NURSING FACILITY CARE*			
(Participating with Medicare) You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after having left the hospital			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $[99] a day	Up to $[99] a day	$0
101st day through 365th day of a benefit period	$0	$10 a day	Balance
Beyond the 365th day of a benefit period	$0	$0	All Costs
(Not Participating with Medicare) You must meet Medicare's requirements, including having been in a hospital for at least 3 days and transferred to the facility within 30 days after having left the hospital			
1st day through 365th day of a benefit period	$0	$8 a day	Balance
Beyond the 365th day of a benefit period	$0	$0	All Costs

BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0

HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	Coinsurance	$0

MEDICARE SUPPLEMENT 1
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

**Once you have been billed $100 of Medicare-approved amounts for covered services (which are noted with a double asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests and durable medical equipment			
First $100 of Medicare-approved amounts**	$0	$100 (Part B Deductible)	$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Outpatient treatment for biologically-based mental disorders (for services covered by Medicare)			
First $100 0f Medicare-approved amounts**	$0	$100 (Part B Deductible)	$0
Remainder of Medicare-approved amounts	50%	50%	$0
Outpatient treatment for biologically-based mental disorders (for services not covered by Medicare)	$0	100%	$0
Outpatient treatment for other mental health disorders (for services covered by Medicare)			
First $100 of Medicare-approved amounts**	$0	$100 (Part B Deductible)	$0
Remainder of Medicare-approved amounts	50%	50%	$0
Outpatient treatment for other mental health disorders (for services not covered by Medicare)			
First 24 visits per calendar year	$0	100%	$0
Visits 25 and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare-approved amounts**	$0	$100 (Part B Deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR (continued)

CLINICAL LABORATORY SERVICES-BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

SPECIAL MEDICAL FORMULAS MANDATED BY LAW			
Covered by Medicare			
First $100 of Medicare-approved amounts **	$0	$100 (Part B Deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
Not covered by Medicare	$0	All allowed charges	Balance

MEDICARE SUPPLEMENT 1
MEDICARE PARTS A & B

**Once you have been billed $100 of Medicare-approved amounts for covered services (which are noted with a double asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE			
Medicare-approved services			
-Medically necessary skilled care services and medical supplies	100%	$0	$0
-Durable medical equipment			
First $100 of Medicare-approved amounts**	$0	$100 (Part B Deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0

MEDICARE SUPPLEMENT 1
OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL-NOT COVERED BY MEDICARE			
Only the services listed above while traveling outside the United States	$0	Remainder of charges (including portion normally paid by Medicare)	$0
OUTPATIENT PRESCRIPTION DRUGS - NOT COVERED BY MEDICARE	$0	$0	All Costs
[ANY NEW OR INNOVATIVE BENEFITS OFFERED BY ISSUER SHALL BE DESCRIBED HERE]			

MEDICARE SUPPLEMENT 2
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general hospital nursing and miscellaneous services and supplies and licensed mental hospital stays for biologically-based mental disorders or other mental disorders prior to the 190-day Medicare lifetime maximum			
First 60 days of a benefit period	All but $[792]	$[792] (Part A Deductible)	$0
61st through 90th day of a benefit period	All but $[198] a day	$[198] a day	$0
91st day and after of a benefit period:			
- While using 60 lifetime reserve days	All but $[396] a day	$[396] a day	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare eligible expenses	$0
- Beyond the additional 365 days	$0	$0	All Costs
Licensed mental hospital stays not covered by Medicare for biologically-based mental disorders			
First 60 days of a benefit period	$0	100% of Medicare eligible expenses	$0
61st through 90th day of a benefit period	$0	100% of Medicare eligible expenses	$0
91st day and after of a benefit period:			
- While using 60 lifetime reserve days	$0	100% of Medicare eligible expenses	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare eligible expenses	$0
- Beyond the additional 365 days	$0	$0	All Costs

MEDICARE SUPPLEMENT 2
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD (continued)

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Licensed mental hospital stays not covered by Medicare for other mental disorders:			
- First 120 days per benefit period (at least 60 days per calendar year) less days covered by Medicare or plan in that calendar year			
First 60 days of a benefit period	$0	100% of Medicare eligible expenses	$0
61st through 120th day of a benefit period	$0	100% of Medicare eligible expenses	$0
- Days after 120 days per benefit period (or 60 days per calendar year) less days covered by Medicare or plan in that calendar year	$0	$0	All Costs

MEDICARE SUPPLEMENT 2
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD (continued)

SKILLED NURSING FACILITY CARE*			
(Participating with Medicare) You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after having left the hospital			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $[99] a day	Up to $[99] a day	$0
101st day through 365th day of a benefit period	$0	$10 a day	Balance
Beyond the 365th day of a benefit period	$0	$0	All Costs
(Not Participating with Medicare) You must meet Medicare's requirements, including having been in a hospital for at least 3 days and transferred to the facility within 30 days after having left the hospital			
1st day through 365th day of a benefit period	$0	$8 a day	Balance
Beyond the 365th day of a benefit period	$0	$0	All Costs

BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0

HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	Coinsurance	$0

MEDICARE SUPPLEMENT 2
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

**Once you have been billed $100 of Medicare-approved amounts for covered services (which are noted with a double asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests and durable medical equipment.			
First $100 of Medicare-approved amounts**	$0	$100 (Part B Deductible)	$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Outpatient treatment for biologically-based mental disorders (for services covered by Medicare)			
First $100 of Medicare-approved amounts**	$0	$100 (Part B Deductible)	$0
Remainder of Medicare-approved amounts	50%	50%	$0
Outpatient treatment for biologically-based mental disorders (for services not covered by Medicare)	$0	100%	$0
Outpatient treatment for other mental health disorders(for services covered by Medicare)			
First $100 of Medicare-approved Amounts**	$0	$100 (Part B Deductible)	$0
Remainder of Medicare-approved Amounts	50%	50%	$0
Outpatient treatment for other mental health disorders (for services not covered by Medicare)			
First 24 visits per cal year	$0	100%	$0
Visits 25 and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare-approved amounts**	$0	$100 (Part B Deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES- BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR (continued)

SPECIAL MEDICAL FORMULAS MANDATED BY LAW			
Covered by Medicare			
First $100 of Medicare-approved amounts**	$0	$100 (Part B Deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
Not covered by Medicare	$0	All allowed charges	Balance

MEDICARE SUPPLEMENT 2
MEDICARE (PARTS A & B)

**Once you have been billed $100 of Medicare-approved amounts for covered services (which are noted with a double asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE			
Medicare-Approved Services			
-Medically necessary skilled care services and medical supplies	100%	$0	$0
-Durable medical equipment			
First $100 of Medicare-approved amounts**	$0	$100 (Part B Deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0

MEDICARE SUPPLEMENT 2
OTHER BENEFITS - NOT COVERED BY MEDICARE

***You must satisfy only one $35 prescription drug deductible per calendar quarter.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL-NOT COVERED BY MEDICARE			
Only the services listed above while traveling outside the United States	$0	Remainder of charges (including portion normally paid by Medicare)	$0
OUTPATIENT PRESCRIPTION DRUGS- NOT COVERED BY MEDICARE			
Generic Drugs			
First $35 of allowed charges per calendar quarter***	$0	$0	$35
Remainder of charges	$0	Balance	$0
Brand-Name Drugs			
First $35 of allowed charges per calendar quarter***	$0	$0	$35
Remainder of charges	$0	80%	Balance

[ANY NEW OR INNOVATIVE BENEFITS OFFERED BY ISSUER SHALL BE DESCRIBED HERE]

DISCLOSURE STATEMENTS

Instructions for Use of the Disclosure Statements for Health Insurance Policies Sold to Medicare Beneficiaries that Duplicate Medicare

1. Section 1882(d) of the federal Social Security Act [42 U.S.C. 1395ss], prohibits the sale of a health insurance or long-term care insurance policy (the term policy includes certificate) to Medicare beneficiaries that duplicates Medicare benefits unless it will pay benefits without regard to a beneficiary's other health coverage and it includes the prescribed disclosure statement on or together with the application for the policy.

2. All types of health insurance policies that duplicate Medicare shall include one of the attached disclosure statements, according to the particular policy type involved, on the application or together with the application. The disclosure statement may not vary from the attached statements in terms of language or format (type size, type proportional spacing, bold character, line spacing, and usage of boxes around text).

3. State and federal law prohibits insurers from selling a Medicare supplement policy to a person that already has a Medicare supplement policy except as a replacement policy.

4. Property/casualty and life insurance policies are not considered health insurance.

5. Disability income policies are not considered to provide benefits that duplicate Medicare.

6. Long-term care insurance policies that coordinate with Medicare and other health insurance are not considered to provide benefits that duplicate Medicare.

7. The federal law does not preempt state laws that are more stringent than the federal requirements.

8. The federal law does not preempt existing state form filing requirements.

9. Section 1882 of the federal Social Security Act was amended in Subsection (d)(3)(A) to allow for alternative disclosure statements. The disclosure statements already in 211 CMR 71.100 –Appendix H remain. Carriers may use either disclosure statement with the requisite insurance product. However, carriers should use either the original disclosure statements or the alternative disclosure statements and not use both simultaneously.

[Original disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- other approved items and services

Before You Buy This Insurance

- ✔ Check the coverage in **all** health insurance and long-term care insurance policies you already have.
- ✔ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✔ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Original disclosure statement for policies that provide benefits for specified limited services.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any of the services covered by the policy are also covered by Medicare

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- other approved items and services

Before You Buy This Insurance

- ✔ Check the coverage in **all** health insurance and long-term care insurance policies you already have.

- ✔ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

- ✔ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Original disclosure statement for policies that reimburse expenses incurred for specified disease(s) or other specified impairment(s). This includes expense-incurred specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

Before You Buy This Insurance

- ✔ Check the coverage in **all** health insurance and long-term care insurance policies you already have.
- ✔ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✔ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Original disclosure statement for policies that pay fixed dollar amounts for specified disease(s) or other specified impairment(s). This includes specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits because Medicare generally pays for most of the expenses for the diagnosis and treatment of the specific conditions or diagnoses named in the policy.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

Before You Buy This Insurance

- ✔ Check the coverage in **all** health insurance and long-term care insurance policies you already have.
- ✔ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✔ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Original disclosure statement for indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any expenses or services covered by the policy are also covered by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

Before You Buy This Insurance

- ✔ Check the coverage in **all** health insurance and long-term care insurance policies you already have.
- ✔ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✔ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Original disclosure statement for policies that provide benefits upon both an expense-incurred and fixed indemnity basis.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any expenses or services covered by the policy are also covered by Medicare; or
- it pays the fixed dollar amount stated in the policy and Medicare covers the same event

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice care
- other approved items & services

Before You Buy This Insurance

- ✔ Check the coverage in **all** health insurance and long-term care insurance policies you already have.
- ✔ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✔ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Original disclosure statement for other health insurance policies not specifically identified in the preceding statements.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

 the benefits stated in the policy and coverage for the same event is provided by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

Before You Buy This Insurance

- ✔ Check the coverage in **all** health insurance and long-term care insurance policies you already have.
- ✔ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✔ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Alternative disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Alternative disclosure statement for policies that provide benefits for specified limited services.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits under this policy.

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Alternative disclosure statement for policies that reimburse expenses incurred for specified diseases or other specified impairments. This includes expense-incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy. Medicare generally pays for most or all of these expenses.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Alternative disclosure statement for policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Alternative disclosure statement for indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Alternative disclosure statement for policies that provide benefits upon both an expense-incurred and fixed indemnity basis.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice care
- other approved items & services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Alternative disclosure statement for other health insurance policies not specifically identified in the preceding statements.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.